TAKING TEXAS TOBACCO FREE

CANCER PREVENTION & RESEARCH INSTITUTE OF TEXAS

Taking Texas Tobacco Free:

A Step-by-Step Guide to Implementing a Multi-Component Tobacco Free Workplace Program within Substance Use Treatment Settings


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Acknowledgements

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Introduction to the Taking Texas Tobacco Free Program

What is TTTF? *Taking Texas Tobacco Free* (TTTF) is an evidence-based organizational-level intervention funded by the Cancer Prevention & Research Institute of Texas that provides practical advice, technical assistance, consultation, education, training, and treatment resources to behavioral health and substance use disorder (SUD) treatment centers throughout the state of Texas. Additionally, TTTF works with organizations treating clients with SUDs who are members of vulnerable populations who have increased rates of smoking, including those experiencing homelessness, identifying as members of a sexual minority, who are disadvantaged single mothers, former prisoners, and who are of lower socio-economic status. TTTF assists organizations to implement a multi-component tobacco-free workplace program that includes: 1) tobacco-free workplace policies; 2) education to all staff; 3) the integration of tobacco use assessments (TUAs; e.g., tobacco use screenings) into routine practice; 4) training of clinicians on evidence-based tobacco use cessation services and their provision to staff and clients; and 5) a community engagement and outreach component.

Why focus on SUD treatment centers? The focus on organizations treating individuals with SUDs is critically important to cancer prevention because these individuals: 1) are estimated to have smoking rates as high as 87%[1-7]; 2) 51% die from tobacco-related as opposed to 34% alcohol-related illnesses while in treatment[8,9]; 3) experience higher cancer incidence because the concurrent use of tobacco and alcohol is associated with greater risk of several cancers, particularly those of the aero-digestive track and liver,[10] and mouth and neck, than use of alcohol alone,[10-14] as combined use has a multiplicative effect on risk;[10,15,16] and 4) despite the existence of effective treatments and overall decline in tobacco use among the general population, have smoking rates that are two to four times higher than in the general population.[2,3] Moreover, individuals with opioid use disorder are particularly susceptible to tobacco dependence, given the direct correlations between perceived alleviation of pain and opioid use.[17] Smokers being treated for pain with chronic opioid therapy use higher doses of opioids which puts them at increased risk of misuse,[18,19] as smoking increases pain sensitivity leading to higher doses of opioids to alleviate pain.

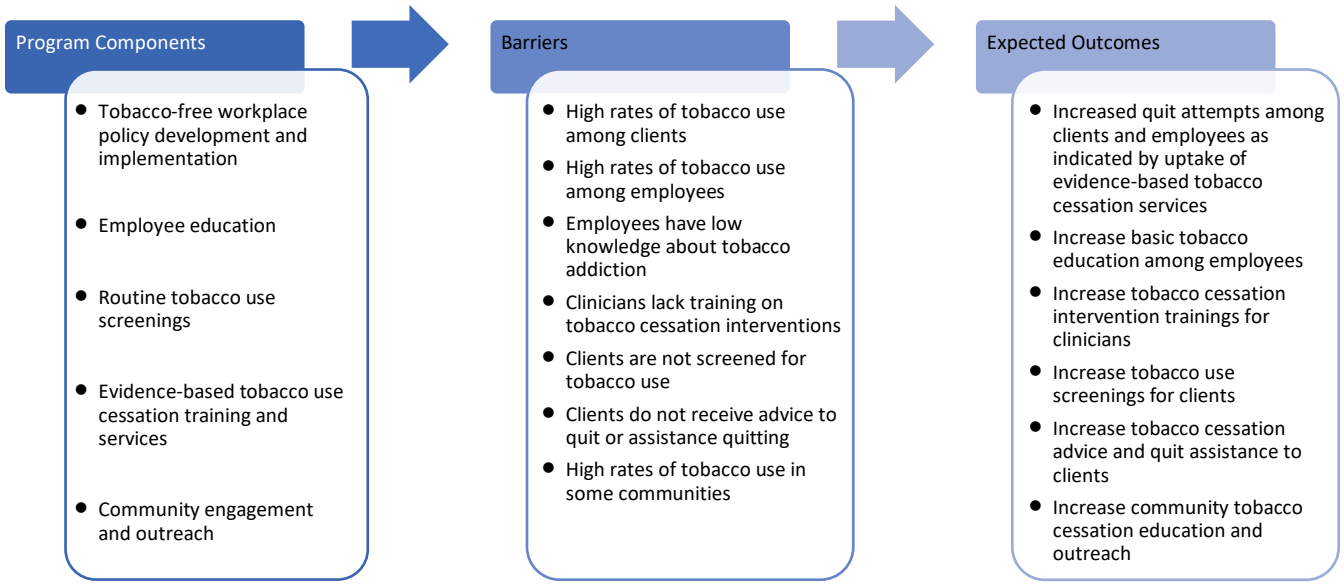
While smoking rates among the general population have steadily decreased from 20.9% to 15.5% from 2006-2016, rates of smoking among those with behavioral health issues rates have remained relatively static at 35.8%.[20] Likewise, for homeless individuals, smoking rates are 73%;[21] among sexual minority adults rates are 27.4%;[22] rates for former prisoners range from 50-83%;[23]and 25.3%[20] of those living below the poverty level smoke. Organizational-level interventions are necessary to affect tobacco use rates among subgroups experiencing tobacco-related disparities because they yield greater reach with enhanced cost-effectiveness relative to individual-level treatments.[24,25] Therefore, evidence-based tobacco-free workplace programs like TTTF have the potential to make a significant impact on the prevention of tobacco-related cancers among individuals with SUDs and those that serve them.

Are tobacco-free policies effective? Comprehensive tobacco-free workplace programs are multi-component programs that include a tobacco-free workplace policy as well as attention to the identification and treatment of tobacco users through provider training/education and the implementation of regular screening and treatment/referral policies/procedures. Tobacco-free workplace policies that completely prohibit the use of tobacco and other nicotine delivery products on worksite property alone are an effective means in reducing tobacco use and dependence.[26] For example, smokers employed in workplaces with complete smoking bans are more likely to consider quitting and quit at higher rates than those employed at workplaces with partial or no bans.[27] The implementation of tobacco-free workplaces, particularly when coupled with the provision of tobacco use cessation resources, may also reduce smoking rates among those who continue to smoke.[27] Additional benefits include reduced absenteeism, reduction in smoking-related fires, increases in staff productivity, averted

medical costs,[28] sustenance of cessation through the elimination of tobacco cues, and a reduction in exposure to environmental tobacco smoke (ETS) among non-smokers.[26-28]

How does TTTF work? TTTF was specifically designed to increase the capacity for, and the provision of, evidence-based interventions for tobacco use in SUD and behavioral health clinics because the delivery of evidence-based interventions is known to increase quit attempts and cessation.[29-31] TTTF program components were designed to address multi-level barriers and thereby meet the need for evidence-based service provision within the targeted healthcare centers. Primary program components entail tobacco-free workplace policy implementation and enforcement (organization-level); staff education about tobacco use hazards (staff-level); provider training to regularly screen for and address tobacco dependence via intervention (provider-level); and community outreach to address and prevent tobacco use more broadly (community-level). These are further explicated in the figure below. To maximize buy-in at the targeted centers, we use a toolkit-based approach to facilitate organizational, staff and provider, and community-level changes in how tobacco use is being addressed, which allows stakeholders in these settings to identify their needs at each level and select evidence-based strategies for best addressing them within their context.

Figure 1. TTTF Major Components and How They Address Barriers at SUD Treatment Centers



Implementation Components of Taking Texas Tobacco Free

Program modifications for SUD treatment settings. The TTTF program was previously successfully implemented in behavioral health settings;[32-35] thus, many sample documents provided in this guide are from centers within those settings. However, they are equally applicable to SUD treatment centers. In addition, the TTTF program has been specifically modified to address issues relevant to SUD treatment settings and populations. These modifications include: 1) explicitly framing tobacco use as a chronic condition that increases individuals' risk for non-nicotine substance use disorder lapses and relapse; and 2) explicit linkages to other screening/treatment terminology currently used in SUD settings regarding other substances of abuse.

The purpose of the implementation guide. The purpose of this *Implementation Guide* is to share the TTTF program with the broader public and centers outside of Texas, and to offer step-by-step guidance for its implementation in other settings. On the following pages, the reader will find our recommendations, experience, and wisdom garnered through our work in disseminating and implementing the TTTF program across Texas. We have organized the guide roughly by each component of the multi-component program, but it is important to acknowledge that each component is implemented concurrently, as opposed to in a sequential manner. All components are important, and attending to each will facilitate the impact that your center can have on addressing tobacco use and preventing cancer among your clients. We are exceedingly pleased to share our experiences with you, and are available to your center should questions arise during your tobacco-free journey.

Sincerely,

The TTTF team

Tobacco-Free Workplace (TFW) Policy Processes

There is ample evidence showing that exposure to environmental tobacco smoke (ETS) causes death and disease among non-smokers. The Surgeon General has determined there is no safe level of exposure. The Surgeon General's report cited numerous studies that found "an association between workplace smoking policies, particularly more restrictive policies, and decreases in the number of cigarettes smoked per day, increases in attempts to stop smoking, and increases in smoking cessation rates."[36]

Implementing a TFW policy can lead to more quit attempts and greater quit rates among clients and staff alike. This is important because SUD treatment staff often smoke at rates higher than the national or state average. For example, some studies suggest that smoking rates among staff at behavioral health and substance use treatment facilities are between 20% [37-39] and 40%.[40-42] If not proactively addressed, these high rates of smoking among staff can lead to a reluctance to address tobacco use among clients.[43-45] Overall, this results in a missed opportunity to contribute to the lifelong health of clients and staff through proactively addressing tobacco use and dependence in these settings. [Please note that when we refer to tobacco use herein, we refer to the use of all tobacco products and include electronic nicotine delivery systems (ENDS) in our conceptualization.] Therefore, the implementation of a TFW policy can facilitate a "teachable moment" to address these issues among all organizational stakeholders for the betterment of their health and welfare. Implementing TFW policies at SUD treatment centers are critical interventions to creating an environment that is healthy, welcoming, and conducive to supporting people who are trying to quit using tobacco products.

Development and enforcement of TFW policies, including all smokeless tobacco and ENDS and covering all buildings and grounds, are an effective population-based intervention. These policies have the effect of changing the culture and norms of previously accepted behavior. In many cases, a TFW policy directly supports the center's mission of promoting a healthy place to receive health care.

Tobacco-free policies protect all people from exposure to harmful ETS, support people who are making a quit attempt, discourage continued tobacco use while prompting people to try to quit, and makes using tobacco less accessible and convenient.[46]

Policy Development and Implementation

- A work group should be convened to develop and implement a strong tobacco-free workplace policy that applies to all clients, staff, visitors and vendors, includes all smokeless and ENDS and covers all sites
- View 6-month Policy Development Timeline
- Decide on a TFW policy start date 6-9 months in advance and communicate it clearly verbally and visibly through signs to prepare staff and clients for transition
- All staff should receive ongoing training in intervention and communication skills on how to respectfully address tobacco use violations
- Post-implementation, conduct routine surveillance checks to ensure enforcement of policy and implement an improvement plan if violations are discovered

Tobacco Work Group Development and Composition

In developing and implementing a 100% TFW policy, the executive management team should convene, as staffing allows, one or more work groups tasked to facilitate the following procedures and protocols: 1) integrate tobacco use assessments into routine clinical practice; 2) provide tobacco treatment resources to clients and staff; 3) develop sustainable tobacco cessation training resources for all staff; 4) disseminate information about the policy; and 5) provide general education about the harms of tobacco use and the benefits of quitting - to staff, clients, visitors and the community at large.

When possible, the work group/s should be composed of a wide range of center staff including a project leader to coordinate all activities. Members of the work group/s may include program directors and/or managers and training coordinators as well as representatives from information technology (IT), human resources, facilities, medical records, quality improvement/assurance, public relations/communications, pharmacy (if applicable), nursing, and community outreach. The inclusion of clients and/or peer counselors may be considered as well. Members of the work group/s should serve as champions of the tobacco-free program and process, and membership should not be limited to non-tobacco users.

The work of implementing a TFW at a SUD treatment center may be most efficiently accomplished by dividing the labor into two main parts: 1) responsibility for developing and implementing the tobacco-free workplace policy; and 2) responsibility for developing policies and procedures to screen for tobacco use and provide treatment services to clients and staff. The work groups will develop communication plans to inform staff, clients and the community-at-large of the tobacco-free program.

Crafting a Tobacco-Free Workplace (TFW) Policy

The first step in crafting a TFW policy is for the Chief Executive Officer/Executive Director to decide that the organization is going to execute the policy. Once this decision has been made, a work group will be charged with identifying sample policies, collaborating with key stakeholders to create a draft policy, and presenting the policy to the governing board or executive management team for approval. Approval of the policy by the board and executive management is vital to the success of the program implementation.

A strong TFW policy:

- Applies to all staff, clients, contractors, vendors, and visitors
- Includes all tobacco products, without exception of ENDS
- Applies to all sites (owned and leased), including housing units owned and/or operated by the organization, parking lots, and official vehicles

The most restrictive policy is the most effective and easiest policy to implement and enforce. Eliminate loopholes and exemptions that allow people to use tobacco products in certain areas or at certain times. We do not recommend the use of designated smoking areas – it is best to bring the entire workplace tobacco-free at once, as this presents the clearest direction about expectations and because having designated smoking areas may only deter the effectiveness of the policy in engendering quit attempts.

Appendix A: Santa Maria Hostel tobacco-free policy, Alpha Home tobacco-free policy, and Billy T. Cattan Recovery Outreach tobacco-free policy

It is important to set a date for the TFW policy implementation as soon as possible, even before a policy has been crafted. The benefits of identifying a tobacco-free date early provides the work group/s with a deadline to work toward, and allows the organization enough time to announce their intentions and prepare staff and clients for the changes to come. This allows opportunities for dialogue (e.g., town hall meetings) and the development of materials and signage. Ample permanent signage placed on the grounds and inside all buildings will serve as both notification and reminder of the policy to staff, clients, contractors, vendors, and visitors.

Things to Consider when Drafting a Tobacco-Free Workplace Policy:

- Should there be any circumstances whereby staff are allowed to use tobacco products during work hours (e.g., if they are trying to quit conventional cigarette smoking using an e-cigarette)?
- Can staff be in viewing distance of clients (e.g., off the organization grounds but still in sight) when using tobacco?
- Are there any acceptable circumstances whereby staff can use tobacco in presence of clients or along with clients?
- Can employees smell like smoke during work hours? Is there a statement in dress code policy?
- What are the disciplinary actions for staff who violate the tobacco-free workplace policy?

When identifying a TFW policy implementation date, allow the organization and its constituents about 6 to 9 months to plan and prepare before the policy takes effect. Setting a date too soon may not allow sufficient preparation time for staff and clients to process and/or be informed about the change. Setting a date too far in advance draws out the process and contributes to a loss of urgency and may lead to complacency within the work group/s and may convey messaging to staff and clients that the change is not important.

Our website provides a comprehensive timeline with tasks that should be accomplished to implement a 100% TFW policy. The timeline is available in an excel format. Please visit our website for more information.

Details for staff training and enforcement of the policy should be included in the TFW policy. This will include informing and training all new staff on the policy and its associated rationale, resources for quitting tobacco, and how to approach others on campus who may be violating the policy. Language should also include a plan regarding disciplinary actions for staff who violate the TFW policy.

TFW Policy Communication Plan

Communication with staff and clients at all stages of the TFW policy development is imperative. There is no single right way to communicate information on the TFW policy, but a lack of communication will provide fertile ground for rumors, mistrust, confusion, resistance, and anxiety for staff and clients alike.

Information should be communicated as early as possible and on a regular and consistent basis. As soon as executive management has set a date to become 100% tobacco-free, this information should be communicated to all staff. In this communication, a general overview of the policy should be included along with an explanation of what this will mean for staff and clients. Information should be provided regarding opportunities for staff to share their questions/concerns through town hall meetings, staff meetings and online/email avenues. All thoughts should be welcomed as they reduce staff and client anxiety and create a venue to share new ideas. The meetings are not a place to debate if the policy should take effect; rather, the meetings should focus on how to make the transition as smooth as possible. An intranet site or similar resource to share information should be created and staff should be directed to this site.

For example, the Heart of Texas Region MHMR center in Waco, Texas held three town hall forums in which staff and clients were able to ask questions, express their concerns, and provide feedback on the upcoming policy. The forums took place about 3 months prior to the implementation of the TFW policy. Turnout to the forums was low and the majority of the participants were tobacco users who did not agree with the new policy, but they were appreciative of having the opportunity to share their thoughts. The CEO of Heart of Texas Region MHMR center facilitated 2 of the 3 forums.

Appendix B: E-mail Notifications to Employees

Signage and other communication materials should be developed to inform and educate clients about the TFW policy and provide opportunities and venues for them to express their concerns and have their questions answered. However, town hall discussions with clients should be separate from meetings with staff.

Appendix C: Tobacco-free Workplace Signage Notifications

Business card-size information/education cards are a great and inexpensive way to supplement permanent workplace signage about the new policy. These can be created for staff to give to people who violate the policy. Typically, one side of the card includes information on the policy and the other side includes information on tobacco treatment resources that are available through the organization.

As details of the policy are developed and the implementation date approaches, notifications should be forwarded to all contractors and vendors. In some cases, contracts may have to be rewritten or language added to reflect the new policy and a statement of agreement from the contractor. Training opportunities can be included in the notifications.

Appendix D: Notification to Community Partners

Hiring announcements should include a statement that the organization is, or will become, a 100% tobacco-free organization.

As the implementation date nears, frequent communications should be emailed to staff. The use of multiple communication channels is recommended, including electronic newsletters, communication from CEO/ED, posters/flyers, screensavers on computers and digital kiosks in lobbies. In addition, human resources and insurance updates should be used to relay important information to staff, clients, and visitors.

The public relations/communications department should create a series of press releases for the local media to promote the policy and educate the community of the impending policy change. A press release should be sent to all media outlets the day before the policy goes into effect and again on the first day the TFW policy becomes effective.

Appendix E: Tobacco-free Kick Off Event

Tobacco-free Kick Off Event

Although leadership and employees may fear the worst when the implementation day arrives, the day typically begins and ends with little to no disruption in daily services. The advanced communication, the town hall meetings, the transparent discussions, and availability of tobacco treatment resources has paid off and the implementation goes relatively smoothly. This has been the repeated experience of many behavioral health and substance use treatment centers that have effectively implemented a tobacco-free campus policy, including those participating in the TTTF program.

It is essential that all permanent signage be in place on the implementation date and that all ashtrays, smoking buckets, and cigarette receptacles be removed from the grounds. All smoking gazebos and smoking areas should be cleaned and refreshed, and perhaps repurposed as a place to get shade and enjoy fresh air. This may be a great time to begin a new norm of utilizing a former smoking gazebo as a space to hold a group, a staff meeting, or to have lunch. All permanent signage should be in place on the implementation day as a reminder that smoking and tobacco use is not allowed on any of the grounds. Clients in residential settings will turn over all tobacco products to staff once the policy becomes effective, but should be given the opportunity prior to this date to release these products to loved ones/visitors.

Appendix F: Permanent Signage

There will be clients and staff who violate the TFW policy, either accidently or intentionally. It is very important that these early violations are addressed immediately in a polite, respectful and empathetic manner. Staff should have an ample supply of quit cards to distribute to people and the cards should be placed in waiting rooms, lobbies, and other common areas.

How to Effectively Communicate the Tobacco-free Workplace Policy:

- Be polite and respectful at all times
- Express empathy and understanding – listen to their story and concerns
- Do not take criticism of the policy personally - you are doing your job to ensure the health and safety of everyone
- Understand the dynamics of nicotine withdrawal and using tobacco as a coping skill; people are reverting to an ingrained and previously acceptable behavior
- Share the importance of compliance with the policy and what you would like to see happen in the future
- Share information on tobacco treatment resources and encourage the person to talk to their case manager or provider at any time to get more information

To celebrate the TFW policy implementation day, plan a tobacco-free kick-off event to thank the work group/s for their time and effort in the process. If your organization is doing a tobacco-free kickoff, invite the local press to be part of the event. The general public, contractors and vendors, and community partners should also be invited.

Emails should be sent to all staff requesting their compliance with the policy and encouraging all staff to address violations as they occur.

Ideally, an organization is not implementing a TFW policy in isolation. Many other initiatives are taking place concurrently to screen people who use tobacco and offer tobacco treatment services (see next section).

Model of Success - Billy T. Cattan Recovery Outreach, Victoria, Texas

- Billy T. Cattan Recovery Outreach (BTCRO) is an intensive outreach substance use treatment center located in Victoria, Texas. BTCRO maintains a caseload of approximately 500 clients per year from a nine county catchment area from the southeast region of Texas.
- The director of BTCRO (Daniel Barrientos), decided to implement a comprehensive 100% worksite program as the center would be moving into a new facility: "[The board of directors] were all for having a policy in place and having products available to help individuals who were trying to quit smoking or wanted to quit smoking. Initially, the process was making the staff aware that this was going to be coming down the line, and the second part of that was having the staff notify the clients that this was coming so that they could be prepared for the fact that they would no longer be allowed [to smoke]."
- Over a four-month period, a tobacco-free worksite policy was drafted, staff were trained on tobacco dependence treatment, nicotine replacement therapy (NRT) was ordered, and the director attended a Certified Tobacco Treatment Specialist training. On May 1, 2018, BTCRO moved into their new tobacco-free facility and they were prepared to begin providing tobacco treatment services to their clients.
- As they began to provide groups at their new facility, they began to make nicotine gum or lozenges available to clients to use during groups, even if they had no desire to quit using tobacco, to reduce nicotine withdrawals and cravings. Providing NRT during these groups were essentially mini-quit attempts and many clients realized the NRT helped them not crave nicotine and didn't want to smoke during breaks.
- BTCRO clinical coordinator (Elma Seanz) stated: "You aren't just taking something away, you are offering them an alternative." Based on this model of introducing NRT during groups, approximately 88% of clients have taken advantage of the nicotine replacement therapy program at BTCRO. "There's no question anymore…Now it's just part of our policy, so they hear it when they come in for their intake. It's just a part of what we do…It has become part of our culture." Quitting tobacco is integrated into their clinical services and many clients are successfully quitting tobacco as a result of these efforts.
- Please visit www.TakingTexasTobaccoFree.com to watch a brief video highlight the successful implementation of the 100% tobacco-free workplace program at Billy T. Cattan Recovery Outreach.

Post-implementation Surveillance

It is important to be vigilant about addressing violations at all times. Centers will find that over time, people begin to gravitate to certain areas on the grounds to smoke or use tobacco. No violations to the policy should not be allowable. Consistent enforcement of the policy is essential and ongoing. All staff should have the expectation that the TFW policy will require continuous reinforcement.

Clinic managers should conduct quarterly surveillance checks by walking the grounds looking for piles of cigarette butts. Finding places with tobacco butts may indicate a good area to place a new permanent sign about the policy. Managers should talk to clients about the policy, provide continued training and improvement plans for staff, and contact facilities if any signage has been removed or vandalized or if additional signage is needed.

Appendix G: Surveillance Checklist

Based on the surveillance check, an improvement plan should be developed. All staff should be provided a copy of the surveillance check and tasked with ways to address the issues over the next three months. If improvements are not seen over time, ongoing staff training on effectively talking with clients who violate the policy may be needed.

Some clinics may have a harder time managing violations than others and monthly surveillance should be required for these clinics.

Staff Education

Education about Tobacco Use among SUD Treatment Clients

An essential component of TTTF is the provision of education and training to all staff and providers. Reaching every staff in this process is considered crucial in generating support for TTTF and facilitating new norms about tobacco use. Both groups receive training on how tobacco use and ETS affects the body; tobacco use among individuals with substance use disorders; the tobacco-free workplace policy/program; how to assist others with maintaining compliance with the policy; and basic information about tobacco dependence treatment and effectiveness. This 1-1.5 hour interactive training is provided in person at each clinic (or at a central clinic, as scheduled). As with our past work with behavioral health centers throughout Texas, the content for these presentations is informed by recommendations for best practices in tobacco control,[29] the expertise of team members, and prior tobacco-free workplace implementation work within SUD and mental health settings.[5,45,47] Knowledge within each group will be assessed before and after the training, and knowledge gains should be subsequently shared with center leadership. In our prior TTTF project with behavioral health treatment centers, over 200 on site trainings reached over 4500 staff and providers with sizeable pre/post-knowledge gains (up to 63%) observed. On our website, we have an online Interactive Learning Module for Behavioral Health Staff that may be helpful for education of staff and clinicians.

Education about the Tobacco-Free Workplace (TFW) Policy

All staff should be provided basic intervention and communication skills to address tobacco use violations on a consistent basis. Addressing violations is the responsibility of all staff and this expectation should be consistently reinforced through staff meetings, all-staff emails, and educational opportunities.

Some staff may be fearful of addressing people who are violating the policy and some will choose to ignore the violators because they do not agree with the policy. It is important to address these reservations and provide opportunities for staff to learn from one another. One example of this is to have a staff shadow another staff who feels comfortable addressing people violating the policy. Staff training will increase comfort levels and confidence through the provision of organizational support for "community enforcement." *It is important to stress that the policy is in place for the health and safety of all people and that everyone plays a role in making it successful.*

In order to reach all staff, educational sessions should be scheduled or provided during staff meetings on an ongoing basis. Program managers are ultimately responsible for the education of their staff and enforcement of the TFW policy at their clinic. Staff should be provided with scripts on how to address violations and educational

opportunities should allow time for staff to role-play having these difficult conversations in small groups with one another. To view a role-play of a staff member having a conversation with a person who is using tobacco on the grounds, please visit: www.TakingTexasTobaccoFree.com.

Staff should be encouraged to share their experiences of addressing violations and discuss how to handle repeated violations at their clinic. Over time, clients and visitors will begin to identify specific areas to use tobacco products, which may be away from people or entrances, but still be on the center's grounds. It is important to anticipate these behaviors and plan to address these violations just as more blatant ones would be handled.

A TFW policy acknowledgement form should be completed by new staff member at onboarding/orientation. It should document that they have read and understand the TFW policy, agree to abide by the policy, understand the course of possible discipline for violating the policy, and agree to actively address any violations of the policy. Alternatively, several centers simply had staff sign and date the TFW policy for their agencies acknowledging receipt of it and agreeing to it.

Appendix H: Policy Acknowledgement

Education to All Staff

Education and training of all staff and providers is essential in the areas of:

- The tobacco-free policy/program
- How to assist in the compliance/enforcement of the policy
- The physical effects of tobacco and electronic nicotine delivery systems (ENDS)
- Tobacco use among people with substance use disorders
- Tobacco dependence treatment and effectiveness

To ensure program sustainability, this training should be embedded within New Employee Orientation

Ongoing Training

Keeping knowledge current and appreciation for the purpose behind the tobacco-free workplace is essential to its sustainability. This is particularly important given that SUD treatment centers historically have high staff turnover rates. Therefore, it is essential to focus on adequately training all new staff and this can be accomplished by embedding the training within New Employee Orientation. New employees can view a tobacco treatment training module at our website. This training can also be viewed by current staff on an annual basis as a refresher course.

New staff should also receive training on addressing people who break the TFW policy. Business cards violation/treatment resource cards, role-playing, and scripts should be provided to new staff during this training. New staff can also shadow current staff to become familiar with the processes and procedures.

Routine Tobacco Use Screenings

Implementing the TFW policy is an important step in addressing tobacco use and creating a healthy and safe environment for all people, but in isolation it will have limited impact in reducing tobacco use. Protocols and procedures should be created to regularly screen clients for tobacco use and provide resources to help clients quit using tobacco. While SUD treatment centers in Texas are mandated to screen for tobacco use, screening - by itself - is not sufficient. It is vital to follow through on tobacco screenings with individuals in addiction treatment programs, given a hesitancy among clinicians to provide treatment services.[48,49]

Clinicians' comfort regarding the routine screening for tobacco use among clients may be directly connected with the accuracy of their knowledge about the process. Some staff may believe that it is impossible for clients to quit using tobacco. Others may believe that quitting tobacco may overwhelm and thus adversely affect the client's recovery plan to treat alcoholism[50,51] and/or other SUDs.[52,53] However, various research studies show that clients can become tobacco-free when provided support from staff and utilize proven treatment medications with, generally, no adverse impacts on their recovery from SUDs.[47,54-57] On the contrary, research indicates that quitting tobacco results in positive rather than negative outcomes for those with SUDs, including lower risk of relapse, reduction of overall substance use and the promotion of abstinence from other substances.[49,54,55,58-64] We address these, and other, assumptions about tobacco use among individuals with substance use issues in a handout called "Myths and Facts" that can be found in Appendix J (noted later in this document).

Reluctance to engage in regular tobacco use screenings usually decreases when clinicians acquire more knowledge about tobacco use and the benefits of quitting for individuals with SUDs.

The Clinical Practice Guideline *Treating Tobacco Use and Dependence: 2008 Update* (known as the *Guidelines*) outlines evidence-based recommendations to provide tobacco treatment services to clients that all health care providers can use. Some of these behavioral counseling techniques are outlined further in the evidence-based tobacco use cessation training and services section. Meta-analytic studies show that screening for tobacco use leads to a 2.5 times greater likelihood of being tobacco-free for five or more months compared to not screening.[3,30]

Development and Implementation of a Tobacco Use Assessment (TUA)

A work group should be established to develop and implement the processes, procedures, and protocols to routinely screen for tobacco dependence and establish a protocol for referral to treatment, provision of educational materials, etc. As with the TFW policy work group, the composition of the tobacco use assessment (TUA) work group should include a range of stakeholders from the organization. Practice managers from all departments and level of care, IT, quality improvement/assurance, billing/coding, nursing, and counselors are examples of professionals that might be included in this work group.

One of the first steps in developing an organization's TUA documentation is to collect sample TUAs and consider the questions and information that the organization would like to ask. At a minimum, a TUA should be able to collect the following information:

- Current tobacco use status including type of tobacco used, for how long, and how much
- Past quit attempts, longest period of abstinence, and methods used in prior quit attempts
- Exposure to environmental tobacco smoke (e.g., living with a person who smokes)
- Readiness to quit (usually assessed along a continuum)
- Treatment plan and referral options

The *Contemplation Ladder* is a tool that can be used to assess readiness to quit along a continuum.[65] The ladder has a client rate on a scale of 0 to 10 indicating where they are at the present time in thinking about quitting smoking; several of the numbers have text anchors, such as "I have no thoughts about quitting smoking," "I think I need to consider quitting smoking someday," "I think I should quit smoking but I am not quite ready," "I am starting to think about how to reduce the number of cigarettes I smoke a day," and "I am taking action to quit smoking." A client's readiness to quit can dictate the next steps of the intervention (e.g., focus on building motivation and resolving ambivalence about making an attempt, assisting practically with the attempt using cognitive-behavioral counseling and medications, or appropriately direct a referral if the person conducting the screener is not a treatment-providing clinician).

TUAs should be kept relatively short with consideration of the wide range of staff members who will administer the TUA. The TUA should ask about all tobacco products (including ENDS) and not be limited to conventional cigarette smoking. Keep in mind that the TUA can be combined with evidence-based tobacco interventions – particularly the brief public health intervention approaches detailed in the "evidence-based tobacco use training and services" section of this guide (e.g., the 5 A's and 5 R's).

Discussions in the workgroup should include how the TUA will be administered, by whom, how often, and where the TUA should be placed in the electronic health record (EHR) system or if it will be collected on paper charts.

All new clients should be administered a TUA during the intake interview. To ensure that all clients are being screened for tobacco use, a hard stop should be added to the EHR or mandated for staff using paper charts. By utilizing a hard stop, a clinician will be prohibited from moving forward in the EHR until a TUA is completed.

IT staff can provide valuable expertise on the technical capabilities of the EHR system and how to integrate the TUA into the system. Their input will be critical on the formatting of the questions and how the data can be reported. Quality Improvement/Assurance staff should also be included in the decisions about compiling and reporting data, quality assurance, and compliance. All members of the work group should provide input into where the TUA should be placed in EHR to make it easy, convenient and intuitive for staff to complete.

Appendix I: Tobacco Use Assessment and Contemplation Ladder

Integrating screening for tobacco use into routine practice

- Establishment of a tobacco use assessment (TUA) work group to develop and implement processes, procedures and protocols for routinely screening for tobacco use that are essential to motivate clients to quit and provide them with the resources to do so. TUAs should cover:
- Current tobacco use (i.e., type, for how long, and how much)
- Past quit attempts
- Exposure to environmental tobacco
- Readiness to quit (usually assessed along a continuum; e.g., the Contemplation Ladder)
- Treatment plan and referral options
- Integration of the TUA in the EHR or collection on paper charts
- TUA task force should assess availability of within agency evidence-based tobacco treatment resources to all clients and staff and provide referrals if needed

Tobacco Treatment Availability: Planning and Resources

Because part of the TUA includes a referral for treatment or a treatment plan, the TUA work group will also assess what within-agency tobacco intervention resources are already offered. The design and implementation of tobacco treatment programming vary depending on the resources available at a particular health care setting as well as the population being served. Desirable counseling services may include within-agency individual or group sessions, cessation groups offered in the community, or services received pursuant to calling a QuitLine. Medication availability is also important. The work group will want to assure that the interventions are evidence-based and consider training as many staff as possible to provide the service. Tobacco treatment services should be made available to all clients across all levels of service (e.g., outpatient, inpatient, residential).

When tobacco treatment services are available, it is important to outline the processes and procedures regarding how clients will access these resources. All staff members should be able to provide tobacco treatment services and follow up with the client regarding their quit attempt. There must be a way for staff to document treatment goals, progress toward the goals, use of treatment medications, and attendance at individual or group sessions.

If no cessation services are being offered, the TUA work group will need to explore existing programs at other SUD treatment centers and attempt to replicate the services at their organization. For example, there are several resources provided at the Taking Texas Tobacco Free website (www.TakingTexasTobaccoFree.com), at the National Behavioral Network for Tobacco and Cancer Control (www.bhthechange.org), and at the Substance Abuse and Mental Health Services Administration Center for Substance Abuse Treatment (SAMHSA CSAT) https://www.samhsa.gov/about-us/who-we-are/offices-centers/csat. As each organization is unique, existing programs may need to be tailored to individual needs and local context.

We recommend that every center provide behavioral counseling and medication (e.g., NRT) for tobacco cessation to both clients and staff. However, some centers may not have the resources to do this among both clients *and* staff. At a minimum, staff should refer tobacco using staff who want to quit to their state QuitLine. State QuitLines offer free telephone coaching and possibly free NRT. Exact services vary from state to state. A work group member will want to investigate what services are offered by the state's QuitLine. QuitLines can be accessed by phone at 1-800-QUIT-NOW (1-800-784-8669). Additional information about their services can be found online at http://www.naquitline.org/. In Texas and some other states, QuitLine services are provided in Spanish. For services in Spanish, people should call 1-855- DEJELO-YA (1-855-335-3569) or access http://espanol.smokefree.gov. QuitLines also have services in at least 15 additional languages through a third party. Most QuitLines offer an online and/or text message programs. Online and fax referrals may be options that will ensure the client receives a contact call from the QuitLine. If possible, an electronic referral to the QuitLine should be integrated into the EHR to make the referral process very quick and convenient for clinicians.

As within-agency programs are being developed, the TUA task force should explore the tobacco treatment resources that exist within their communities and develop support groups for staff and/or referral processes to groups outside the agency. Local hospital(s), Federally Qualified Health Center's (FQHC), community behavioral health centers, non-profit agencies, county health departments, or community foundations may offer programs. Additionally, non-profit agencies like the American Heart Association, American Cancer Society or the American Lung Association may offer tobacco cessation programs or training for staff to become a group facilitator.

In addition, other resources may be available to the general public, including smoking cessation apps and online programs that are evidence based. Although there are many examples of these resources, one illustrative resource is the Quitter's Circle: https://www.quitterscircle.com/.

Evidence-based Tobacco Dependence Treatment Training and Services

As indicated by the *Guidelines*, approved and recommended treatments for tobacco dependence include behavioral counseling and pharmacotherapy (e.g., medications).[30] The combination of counseling and medication is more effective than either alone.[66] Staff should encourage all clients making a quit attempt to use both counseling and medication. It is important for clients and for staff to know that evidence-based tobacco treatments are effective and can lead to concurrent reductions in stress, anxiety, depression and substance use, while increasing psychological quality of life and positive affect.[67] In fact, research shows that quitting tobacco interventions provided during SUD treatment can increase long-term abstinence by 25%.[49] Below, we describe brief interventions, behavioral counseling options, and common medications used to address tobacco dependence, including NRT and prescription medications. In general, the more cessation sessions a client attends, the increased effectiveness of the "intervention."

The American Psychological Association (APA) has a useful application called *APA SmokeScreen* that can be downloaded for free to a smartphone or tablet through the App Store or Google Play. For more information, visit: http://www.apa.org/pi/health-disparities/resources/mobile-app.aspx

Brief Public Health Interventions for Tobacco Use

According to the *Guidelines*, the interventions for tobacco cessation can be brief (i.e., no more than 10 minutes per clinical encounter) or intensive (i.e., 10 or more minutes per clinical encounter).[30] Brief interventions are characterized by short and practical counseling encounters that can be used by a variety of providers in both outpatient and inpatient healthcare settings. The focus of these interventions will depend on the client's readiness to quit tobacco.

Many tobacco users may not want to quit tobacco within the upcoming 30 days. Indeed, motivation to quit tobacco use may change from day to day, and perhaps even hour to hour based on situational cues. If a client indicates that they do not wish to quit smoking within the next 30 days, clinicians may use the "5 R's." The "5 R's" are used to increase motivation to make a quit attempt, and entail the following steps: 1) ask clients for some **R**easons why quitting may be personally relevant or beneficial to them (1 minute); 2) ask clients about what they perceive as the short-term, long-term, and environmental **R**isks of continued smoking (1 minute); 3) ask clients about what they perceive as the perceived benefits or **R**ewards of quitting (1 minute); 4) ask clients about the barriers or **R**oadblocks to quitting (3 minutes); and 5) **R**epeat these steps each encounter to facilitate motivation to make a quit attempt. Sharing the myths and facts handout may be helpful for educating clients about the dangers of tobacco use.

Appendix J: Myths & Facts Handout

On the other hand, some clients may be interested in quitting tobacco use within the next 30 days. For these clients, the "5 A's" of treating tobacco dependence (**A**sk, **A**ssess, **A**dvise, **A**ssist, and **A**rrange) are recommended as a brief intervention and a quick and easy way for clinicians to begin conversations about tobacco use and – if the client is amenable - determine a further course of treatment. Below is a table describing the "5 A's" of treating tobacco dependence. Our website also offers a video illustrating this procedure, along with a number of other practical and helpful videos: www.TakingTexasTobaccoFree.com.

5 A's of Tobacco Treatment	
	Ask – every client, at every visit, about their tobacco use (e.g., "*Do you use any tobacco use products, even every once in a while*?")
	Assess – their desire to quit using tobacco (e.g., "*Do you want to quit using tobacco in the next 30 days?*")
	Advise – them to quit using tobacco (e.g., "*Quitting tobacco is one of the most important things you can do to improve your overall health*.")
	Assist – those who have a desire to quit to access treatment resources (e.g., "*I am very happy you want to quit. Would you like to hear about the options to help you quit tobacco?*")
	Arrange – a follow-up session to check in on their progress (e.g., "*I would like to meet with you again in two weeks to discuss your progress.*")

Source: Treating Tobacco Use and Dependence: 2008 Update (Available from: https://www.ahrq.gov/professionals/clinicians-providers/guidelines-recommendations/tobacco/index.html)

Administration of the "5 A's" is not solely the responsibility of one staff member: It is most effective when multiple staff are consistently engaging clients with the 5 A's.

Behavioral Counseling

Any health care setting with trained personnel and time allocated for counseling could incorporate more intensive behavioral interventions, which are particularly beneficial to individuals with greater tobacco dependence and with co-morbid physical conditions or substance use disorders. Based on the client's willingness in quitting, intensive interventions could focus on Motivational Interviewing (MI),[68,69] a more in-depth exploration of the "5 A's" detailed above, or on cognitive behavioral and problem solving/skills treatment. When clients are not ready to change their tobacco use, provider's lectures and exhortations to modify their behavior are very unlikely to promote behavior change compared to when clients express their own concerns and reasons for a change. MI is a goal-oriented, patient-centered counseling intervention that aims to strengthen personal motivation for and commitment to achieve a goal;[69] as such, it is especially appropriate for clients who are not ready to change their tobacco use at a particular moment in time. MI is used to explore the individual's beliefs, feelings and values regarding tobacco use, identify any ambivalence about the use and stimulate motivation for behavior change. By using MI, the provider pays attention to expressions of any desire, ability, reasons, and need to stop tobacco use, as well as verbalizations of commitment to quit and any steps toward change. Health care professionals using an MI approach basically use a "guiding" communication style, by creating a balance between asking clients about their tobacco use and intentions to quit, listening nonjudgmentally to their reasons to change or not the tobacco use, and informing them about the benefits of quitting and the resources available.[69] Given that motivation for change can fluctuate during the quitting process, MI can be integrated at any time with other therapeutic models, especially with cognitive-behavioral/problem solving approaches.[70] In the TTTF program, we provide 8 hour introductory MI trainings to our SUD stakeholders and recommend that clinicians obtain further training and ongoing coaching to become comfortable with using this approach with their tobacco using clients. Many resources for additional training can be found on the MI website: www.motivationalinterviewing.org

TTTF providing motivational interviewing training to community partners.

When clients are ready to quit, they are likely to need a more practical focus in counseling. As mentioned earlier, this can entail expanding on the "5 A's" to better understand high-risk situations, make individualized recommendations for coping methods, etc. The *Guidelines* describe many cognitive-behavioral strategies for addressing tobacco use among various population groups,[30] and there are several treatment handbooks available as well.[71] These approaches are discussed during Certified Tobacco Treatment Specialists (CTTS) training, which we recommend for clinicians providing intense interventions for tobacco users. In the TTTF program, we send clinicians to CTTS training to embed this specialized knowledge within centers, and recommended that these new CTTS champions organize further trainings within their centers upon their return to spread the specialized knowledge further within the agency. Additional details on the format, procedures and treatment content of intensive cessation programs including specific population groups (i.e., Latino tobacco users) also exist and can be found in the literature.[72]

Behavioral Counseling Considerations

Behavioral counseling can be offered in individual or group formats. There is no single model for offering individual or group sessions. The most important criteria is that the staff are adequately trained and comfortable helping a person quit using tobacco. Ideally, staff members should be CTTS or have received training to facilitate a specific curriculum (e.g., American Cancer Society's *Quit for Life* program). Like many other group offerings, the work group will need to consider whether to utilize:

- Open groups (new attendees admitted throughout) versus closed groups (no new attendees admitted once group begins)
- An abstinence-focus (quitting completely is the goal) versus non-commitment focus (allow attendees to determine their own goals)
- A fixed number of sessions (curriculum-based group) versus an open-ended structure (no set number of sessions)

The manual *Learning About Healthy Living: Tobacco and You* [73] provides guidance on facilitating fixed, curriculum-based groups, is available at rutgers.edu.

Organizations have used certified peer specialists, navigators, wellness specialists, and case managers and therapists to facilitate tobacco treatment groups. It is important to identify staff who have experience with groups and have received advanced tobacco treatment training.

Medications for Tobacco Use Cessation

There are three nicotine replacement therapies (NRTs) available over the counter, as indicated below:

- Nicotine patch
- Nicotine gum
- Nicotine lozenge

There are additional medications available by prescriptions as indicated below:

- Nicotine nasal spray
- Nicotine inhaler
- Buproprion SR (brand name: Wellbutrin or Zyban) – contains no nicotine
- Varenicline (brand name: Chantix) – contains no nicotine

These medications have been shown to be effective and safe with mild, if any, side effects for most people who use them. Prescription medications, such as varenicline, buproprion, and nicotine nasal spray and inhalers will need a physician's prescription and likely need to be dispensed in a controlled location such as an on-site pharmacy, through an integrated health program pharmacy, or at a retail pharmacy.

Some clinicians and prescribers may be hesitant to prescribe varenicline (Chantix) due to reports of significant side effects impacting mental health status and a black box warning related to these reports. A large scale multi-national study (EAGLE) found no statistically significant difference in reported side effects between people with no history of mental health diagnosis and people who have had a mental health diagnosis.[74] On December 16, 2016, the FDA *removed* the black box warning for varenicline and buproprion due to research showing that there is no relative increase in risk of side effects for people with a mental health diagnosis compared to the general population of tobacco users.

Some pertinent information about these over the counter and prescription tobacco use cessation medications is available through the following link - http://smokingcessationleadership.ucsf.edu, search for Pharmacologic Guide. Additionally, to learn more about the proper use of tobacco cessation medications and possible side effects of the medications, visit our website: www.TakingTexasTobaccoFree.com.

Clinicians dispensing medications for tobacco cessation must also be familiar with the ways in which they interact with other drugs. In addition, prescribers need to understand the ways in which quitting or reducing tobacco use effects the potency of common psychiatric medications, as well as other substances, such as caffeine. Clinical training should cover these topics to enhance this understanding, which is important to ensuring a successful quit attempt and the safety of the clients we treat.

Appendix K: Medication List and Interaction Document

Within the EHR, distribution and ongoing use of tobacco treatment medications should be documented and updated at every follow up visit. Clinicians should document the type of education materials provided to clients, current level of tobacco treatment medication being used, and prescribers should review documentation to make any necessary changes in psychotropic medication levels should a client quit using tobacco. Each center will determine what process works the best for them and which clinicians/titles are responsible for the dispensation of medications to clients.

Tobacco Treatment Medication Availability

Breaking the dependence on tobacco is very difficult; only 3-5% of people are able to quit without any assistance.[75] It is important that processes and procedures be developed to provide convenient and inexpensive access to tobacco treatment medications. These medications should be made available to clients in conjunction with the TFW implementation date. The availability of the medications will likely reduce anxiety and fear among clients (and staff), provide a valuable incentive to make a quit attempt, and show that the organization wants to support tobacco users to quit rather than punish them for using tobacco.

Many SUD treatment centers are concerned about how to pay for tobacco treatment medications for clients. The majority of clients receiving services do not have private insurance, and if they do, NRT and other medications may not be covered.

One way to offset the cost of providing medications is to utilize the Patient Assistant Program (PAP). PAP provides free or very low cost medications to people who meet financial need requirements. Varenicline (Chantix) and buproprion (Wellbutrin/Zyban) are typically available through the PAP formulary.

Centers can also bill for reimbursement for tobacco treatment services (see Billing/Reimbursement section). Revenue generated from the billing will likely not cover the costs for the service, but it could be used to defer some of the cost to purchase NRT or other medications.

To further reduce the cost burden of purchasing NRT, non-profit organizations may be able to access NicoDerm CQ™ patches and Nicorette™ gum and mini lozenges manufactured by GlaxoSmithKline Client Healthcare through their NRT - Direct Purchase Program (DPP). DPP provides NRT to organizations at a significantly discounted rate. For more information on the NRT DPP Program, please contact:

> Michael Conahan
> 908-625-8731
> michael.c.conahan@gsk.com
> National Account Manager - Wellness Partnerships
> GlaxoSmithKline Client Healthcare

Some other options to cover the cost for tobacco treatment medications include collaborating with the agency's development/fund raising staff to solicit funds. Members of a work group can also explore local or regional community foundations, hospital foundations, community donations, or local, regional or state grants. CVS Pharmacy has community grants available to organizations who provide tobacco treatment services. Visit their Community Grants website to learn more: https://cvshealth.com/social-responsibility/our-giving/corporate-giving/community-grants

Tobacco treatment medications should also be made available to all staff members. The work group will want to review their insurance coverage and determine:

- What tobacco treatment medications are covered
- How long can a staff member access the medication
- Any applicable co-pays and/or pre-authorization requirements and
- Whether cessation groups and/or individual counseling charges are covered

Coverage benefits should be communicated to all staff in advance of the TFW policy implementation and staff should be reminded of the benefits on a regular basis before and after the TFW policy becomes effective. Implementing organizational screensavers with this information and/or including it on within-organization media may be helpful to enhance communication.

The Affordable Care Act has mandated that compliant insurance carriers include tobacco cessation services among their coverage. If your organization's insurance plan has limited or no coverage for tobacco treatment services, the Human Resources department should inquire about implementing this required benefit. If medications are not covered under the insurance plan, it becomes critical for the organization to provide tobacco treatment medications to interested staff. For instance, the organization should consider adding tobacco treatment medication expenses as a line item in the general budget. For example, an organization serving approximately 20,000 clients that employs approximately 1,000 staff should expect to budget between $50,000 and $80,000 annually for NRT.

Storage, Tracking & Distribution of Nicotine Replacement Therapies (NRT)

Procedures will need to be developed for the storage, tracking and distribution of NRTs. For storage and distribution, many factors will need to be considered including:

- number of facilities within the center and number of people served at each facility
- storage capacity at various facilities and
- medication dispensing regulations and requirements for various facilities

Based on these factors, some facilities may not be able to store or dispense the NRT. As facilities are ruled out, procedures should be developed to accommodate NRT availability to all clients at all locations. This may involve couriers, staff pickup, etc.

Nicotine patches, gum, and lozenges are over the counter medications and should be stored in a locked cabinet, accessible to a limited number of clinicians, and kept at room temperature. Distribution of NRT products to clients should be noted in their electronic health record or paper chart.

Remember to be aware that NRT products expire – like all medications – and so time until expiration date should guide product distribution to clients and staff. When a new product arrives it should be placed behind the older product so the older product is used first. Staff should follow established protocols to monitor expiration dates and dispose of expired products.

Tracking NRT allocation and distribution across multiple facilities will take some planning and coordination. NRT-related procedures should include how the NRT inventory tracking and reordering of additional NRT will occur as supplies are reduced. It may take time to determine the appropriate amount of NRT needed at each facility. Inpatient facilities and other residential settings will likely need a larger inventory than outpatient facilities.

Over the counter NRT can be dispensed by a variety of clinical staff and at a range of facilities. These processes are highly individualized to specific centers and there is no recommended "model practice." When developing procedures and protocols for the distribution of NRT, it is important to take the following into consideration in addition to inventory tracking and charting of dispensed NRT.

- Which clinics will be providing NRT to clients?
- Which staff can distribute NRT to clients?
- If clients are receiving services at a clinic that has no NRT available, how do clients get NRT?
- Will NRT be provided at extended observation units, respite housing, and crisis services?
- Do clients need to attend individual or group sessions to receive NRT?

Identifying staff members who will dispense the NRT is essential to the processes and procedures for its distribution. As NRT is an over the counter medication a wide array of staff may dispense the products. Staff ranging from case managers, counselors, pharmacy staff, nurses and doctors can all be involved in the distribution of NRT. Ideally, the Chief Medical Officer will sign a standing order so that any appropriate staff members may dispense NRT to clients. Additionally, a procedure should be in place to ensure that a client's primary prescriber is aware that clients they are treating are receiving NRT from the agency.

Appendix L: NRT Storage and Distribution Procedures

Centers should have adequate controls in place to ensure responsible and ethical dissemination of NRT. Centers should avoid allowing clinicians to have a supply of NRT in a desk drawer to be distributed or placing boxes of NRT in common areas for clients to take with little or no supervision or follow up. NRT is commonly diverted for sale on the street if there is not a well thought out strategy for dispensing NRT to only those clients involved in cessation services. As such, NRT should be provided only to people who have a desire to quit using tobacco.

The work group will want to decide for how long clients can receive NRT through their program. Research indicates that it takes a person with a SUD longer to quit using tobacco than other people, so an extended period of NRT use should be considered and accounted for with these clients. Determining how much and how long a client may receive NRT will likely depend on the center's available budget to purchase NRT and the processes of disseminating NRT.

Printed materials on how to properly use NRT should be provided to clients along with information on nicotine withdrawal, craving, and resources to support their quit attempt (within the center, in the community, online, text messaging programs, etc.). There are also videos that may be helpful to clients that are available on our website: www.TakingTexasTobaccoFree.com.

Monitoring Tobacco Use Intervention and Quality Improvement Plans

Once the work group has developed tobacco use screening procedures and staff training curriculums, and has identified procedures to store, track and dispense tobacco treatment medications, the program should be implemented. Clinical staff may feel unprepared, unsure of their skills, skeptical about clients' willingness to attempt to quit using tobacco, and may even question whether it is a good idea for clients to quit using tobacco.

Due to these concerns, early and ongoing monitoring and auditing of clinical charts is very important. Through these audits, staff not following the prescribed procedures and protocols can be identified and improvement plans can be developed.

The audit tool should evaluate the following:

- Number of TUAs completed vs. number of client visits
- Educational materials provided for treatment and reducing exposure to secondhand smoke
- Referrals to internal and/or external treatment resources
- Treatment plan updates and notes on NRT or medication use/progress
- Prescriber consulted about impact on medications during quit attempt

Provision of Evidence-Based Tobacco Use Cessation Training and Services

- Combining behavioral counseling and pharmacotherapy (i.e., medications) has proven most effective in quitting tobacco.
- For tobacco users not ready to quit, clinicians should consider the 5 R's (**R**easons, **R**isks, **R**ewards, **R**oadblocks and **R**epetition) as well as Motivational Interviewing techniques to explore and resolve ambivalence to quit.
- The 5 A's regarding tobacco use (**A**sk, **A**ssess, **A**dvise, **A**ssist and **A**rrange) are a brief and effective intervention to address tobacco use that can be supplemented with other cognitive-behavioral strategies to facilitate quit attempts and sustain abstinence.
- Over-the-counter (OTC) nicotine replacement therapy (NRT; i.e., gum, lozenges, patches) and prescription medications (nicotine inhaler, nicotine nasal spray, buproprion, varenicline) are an important part of an effective and safe treatment plan to quit tobacco.
- The Patient Assistant Program (PAP) can help to offset the costs of NRTs and tobacco medications that may not be covered by medical insurance plans.
- Ongoing monitoring and quality improvement plans for tobacco intervention services are essential to ensure sustained success of the program.
- As ongoing clinician training is essential, the TUA task force should provide continuing tobacco treatment training for clinicians and provide periodic advanced training for nurses and providers and send staff to become CTTS.

To offer best services to individuals served by the agency, specialized trainings and a reporting and monitoring system specific to tobacco treatment services is recommended. This includes a credentialing training as well as chart audits and NRT distribution monitoring.

A specialized tobacco cessation training provides staff with more in depth understanding of tobacco use, how it relates to individuals with SUDs and mental illness and ways to help an individual quit using tobacco. After completion of the training and passing a competency exam, the staff member receives a credential to become the front lines of the process of distributing NRT. While the nicotine replacement voucher is ultimately approved by a prescriber, the credentialed staff member has the knowledge to have a meaningful conversation with individuals served by the center regarding their tobacco use. For example, a four-hour training should cover topics including: *Health Effects of Tobacco Use, Tobacco Use and Behavioral Health Disorders, Assessing for Nicotine Dependence, Tobacco Cessation Aids, Helping an Individual Quit Using Tobacco,* and *Appropriate Documentation of Tobacco-Related Services*. The credential plays an important role in program development to ensure staff members are confident and competent in delivering tobacco cessation services.

To ensure best services are being provided, a comprehensive reporting and monitoring system for tobacco cessation services is recommended. This system is comprised of two parts: 1) auditing of individual charts to ensure that policies and procedures are being followed and documented; and 2) monitoring the distribution of NRT. A comprehensive audit tool and schedule should be used to properly monitor staff member's behavior in regards to tobacco cessation services. The schedule should call for the audit of random staff members from various units monthly. The audit should measure: documenting TUA, person centered care plans, and progress notes. The results are shared with the unit's program manager and individualized training is provided as needed. The auditor can also recognize trends within a unit or across the agency to identify areas of need for tobacco training.

To view a sample TUA audit tool, please visit our website at: www.TakingTexasTobaccoFree.com.

Regarding NRT dispensation monitoring, a report is generated to see the amount of NRT distributed to individuals as well as the duration and regularity of its use. This information can be used to identify individuals that may be overusing NRT. It also allows staff to identify clients that would be good candidates for referrals to more intensive tobacco cessation services, either working directly with a certified tobacco treatment specialist or by being referred to wellness groups. Individuals recognized as either overusing NRT or sporadically using NRT should be referred to a certified tobacco treatment specialist.

By consistently offering trainings for staff and being able to monitor tobacco cessation services and NRT distribution, centers can ensure that their staff feel competent and confident when offering tobacco cessation services.

An improvement plan should address the following:

- Identify the problem (e.g., low percentage of clients are being administered tobacco use assessment)
- State the desired goal (e.g., 100% of clients who have not had a tobacco use assessment administered in the 12 months will be administered a tobacco use assessment)
- State the action required to achieve the goal (e.g., staff will administer the tobacco use assessment to all clients who have not had one completed in the past 12 months)
- Outline improvement timeline (e.g., a report will be run at the end of next month to gauge improvement on assessing all clients for tobacco use)

Quality improvement plans (QIPS's) may require additional training or guidance on how to accomplish the task required. It may involve communicating expectations or providing accurate information to the entire unit so everyone knows what is expected of them.

It is natural that there is a drift in the quality and consistency of services over time if processes are not monitored and evaluated. A monitoring system should be an ongoing activity and information obtained should be used to make necessary changes to clinical processes, as applicable. Staff should evaluate all aspects of existing practices and be willing to change those that have experienced any unintended drift from the original protocol or that have proven to be unhelpful. Screening for tobacco use and providing cessation treatment should be considered an evolving - not a static - service. A treatment program developed today likely will not have the exact same processes in place three years later, and centers will always want to be focused on looking for ways to improve the quality of client services.

Reimbursement, Billing, and Coding

During the process of implementing tobacco treatment services it will be necessary to identify how the services will be documented. Tobacco treatment service codes should be created for the various services offered at the center. Tobacco treatment group and individual service codes will allow the center to track services provided and to identify areas of strength and areas in need of improvement. This information can be used to identify units and individual staff which are having success in implementing tobacco treatment services as well as identify units and staff that may need more training.

The question of billing and reimbursement is often asked in regard to offering tobacco cessation services. In most cases, offering strictly tobacco cessation services is a non-billable service. For example, in the state of Texas, only LMHPs (Licensed Mental Health Professionals) may bill for tobacco cessation services. One can bill for tobacco cessation services when they tie tobacco cessation into billable services already offered by the agency. An example of this would be to tie tobacco cessation services into supportive housing services. To bill under supportive housing services, the staff member must ensure that they are providing the services that meet the requirements to document for the other service.

Ethical Considerations in Tobacco Use Cessation Treatment

Addressing tobacco use within SUD treatment settings may give rise to ethical issues. Some of the ethical issues we have discussed with clinicians implementing TTTF include the following:

- In centers with limited resources, how ethical is it to offer cessation resources if it comes at the cost of reducing the provision of other services?
- For how long should a clinician promote cessation services to a client who is uninterested?
- How long should a clinician use MI and other motivational techniques to try to encourage a quit attempt versus devoting time to the chief complaint?
- Is harm reduction (e.g., reducing the number of cigarettes consumed) an appropriate treatment goal if the client is unwilling to consider complete abstinence?
- Should clients be triaged to receive cessation medications and other clinical services based on their readiness to quit?
- If a medication or treatment is not covered by the client's medical insurance coverage, is it ethical to mention it to them?
- Is it ethical to offer cessation-focused medications to a client who is already overburdened by medications?
- When it is okay to suggest that a client go on a "treatment holiday" for tobacco use cessation? How do you know when to pick cessation treatment back up again?

It is important that clinicians reflect on these ethical questions, as these are situations that can easily arise in the context of tobacco use intervention provision in SUD treatment settings. Professional codes of ethics and consultation with other clinicians may be helpful for working through dilemmas after - and potentially even before - they arise. In our experience with the clinicians we have worked with over the years, the general consensus is that it is highly ethical to routinely address tobacco use among clients given that it is in concert with the broader wellness mission of the organization and because tobacco users are more likely to die from the consequences of tobacco use than from their substance dependence problem. We believe that it is important to engage clients about tobacco use cessation routinely, as motivation and readiness to quit can vacillate day by day or even potentially moment to moment.[76] Clinicians can make a big difference in helping to resolve ambivalence about tobacco use and facilitating quit attempts among their clients.

Quitting tobacco use is extremely difficult and clients may need a great deal of support to maintain abstinence as nicotine dependence is truly a chronic disease – cravings can arise even years after quitting in the presence of certain prompts. SUD treatment clinicians are well-placed to provide the support that clients need to quit. Yet, many clinicians also agree that a "treatment holiday" may also be used on occasion for individuals who have made serious efforts at quitting but seem "stuck." However, they stress that maintaining a close therapeutic relationship is important in offering a holiday, and that the decision about taking one should be well-considered, mutual, and with a clear plan for re-visiting the issue with a fresh outlook after a prescribed period of time. It is recommended that clinicians addressing tobacco use among clients regularly meet to discuss ethical issues that arise in their practice to benefit from each other's experiences and viewpoints.

Ongoing Training: Maintaining Tobacco Treatment Competency

It is essential that as many clinicians as possible are provided a high level of tobacco treatment training and that the training is ongoing and sustainable. A significant barrier preventing clinicians from addressing tobacco use is a lack of training, knowledge, and skills to adequately assist a person with a quit attempt. A robust training program will provide the foundation for a competent and highly skilled clinical staff and ensure that all staff have a consistent level of knowledge. The more staff who have higher levels of tobacco treatment training, the more likely clients are going to be screened, referred for treatment, provided resources for quitting, and followed up.

The TUA work group should incorporate ongoing tobacco treatment training as refresher courses and webinars for current clinicians, provide periodic advanced level training for nurses and providers, and commit to send staff to become CTTS. The CTTS trained staff can assist with the development of training programs and provide valuable clinic level expertise. Ideally, before providing tobacco treatment services to a client, a training program should be developed for credentialing clinicians. Without a consistent training program, untrained staff are less likely to talk with clients about their tobacco use or may provide incorrect and/or potentially harmful information to a client.

Centers should encourage clinicians to take advantage of high-quality free online resources and webinars. Some examples include:

- Smoking Cessation Leadership Center (http://smokingcessationleadership.ucsf.edu/webinars) –
- National Behavioral Health Network For Tobacco & Cancer Control (http://www.bhthechange.org/events/)
- Substance Abuse and Mental Health Services Administration Center for Substance Abuse Treatment (SAMHSA CSAT) https://www.samhsa.gov/about-us/who-we-are/offices-centers/csat

As a way to embed expert knowledge within a setting, it is recommended that centers send staff to become a CTTS. Although there are costs associated with this commitment, it represents a way to sustain local expertise and facilitate future staff training. There are many CTTS programs available across the country. A complete list can be found here: https://attud.org/. Below is a list of some programs we are familiar with:

- Mayo Clinic Nicotine Dependence Education Program: http://www.mayo.edu/research/centers-programs/nicotine-dependence-center/education-program/overview
- University of Massachusetts Medical School: http://www.umassmed.edu/tobacco/
- Rutgers University Tobacco Dependence Program: http://www.tobaccoprogram.org/
- Florida State University College of Medicine: http://med.fsu.edu/index.cfm?page=ahec.tobaccoTreatment

- University of Mississippi Medical Center: Act Center for Tobacco Treatment, Education and Research: http://www.act2quit.org/education/
- University of Colorado School of Medicine: RMTTS-C Program: https://www.bhwellness.org
- University of Texas MD Anderson Cancer Center: https://www.mdanderson.org/conferences and search for Certified Tobacco Treatment Program.

Community Engagement and Outreach

An important and often overlooked component of a comprehensive tobacco-free workplace program is engaging the community. SUD treatment centers do not exist in a vacuum, but are an overall important piece of the safety net services in their community. The development of a comprehensive tobacco program will have direct and indirect impacts on many people and organizations within the broader community.

As mentioned earlier, a center's intentions to adopt a 100% TFW policy should be communicated with all partner agencies, contractors, governmental agencies, and other key stakeholders. This communication may take the form of written letters, emails, disclosures at community coalitions or other meetings, town hall meetings, press releases to the media, announcements in local newspapers, and social media announcements. In all announcements, the communication should focus on what the center intends to do, why the change is taking place, and the anticipated benefits to the community as a result of the change.

SUD treatment centers have collaborative relationships with other organizations in their communities – other SUD treatment providers, FQHC's, behavioral health programs, hospitals, housing authorities, emergency services, community health centers, homeless shelters, and food banks to name a few. Each of these agencies should be notified of your upcoming TFW policy implementation and opportunities to help people break their addiction to tobacco products and improve their health.

Communications among organizations may lead to further collaborations and shared resources. Your center may serve as a referral source or vice versa. Some clients may be discharged from the hospital or an extended observation stay during which they were not permitted to use tobacco and have achieved abstinence from tobacco. In these cases, a direct referral to a tobacco treatment program will support their ongoing abstinence.

Some community partners may have considered adopting a TFW policy, but were hesitant to make the transition. Your center can provide guidance and experience to assist partners to make the transition as smooth as possible. It is important to have partners become tobacco-free to support your client's quit attempts. For instance, imagine how discouraging it could be for a recent former smoker, who is struggling to maintain abstinence, to leave a TFW where they receive their SUD care only to have to walk through clouds of smoke to visit their primary care provider.

Centers may fear community backlash or a decrease in people coming in for services. However, safety net populations typically have nowhere else to receive services so are not inclined to abandon services. The clients most upset by the change are those most in need of cessation services and therefore present a wonderful opportunity for staff. It is important to remember that TFW does not imply that clients are obligated to quit, they just can no longer smoke on center property while receiving services.

It is very valuable that your center shares the successes and challenges with the community. For example, celebrating the TFW policy one year anniversary, writing a letter to your local newspaper editor highlighting your changes, or sharing stories of people who have successfully quit using tobacco because of your policy and the services provided by your center. All of these communication opportunities will increase community support for your efforts and increase the number of partners who will follow your actions.

Appendix M: Tobacco-free Policy Anniversary

Community Engagement and Outreach

- The success of a comprehensive tobacco cessation program requires the engagement of the larger community
- It is essential to communicate the adoption of a 100% TFW policy to all partner agencies, governmental agencies, contractors and other key stakeholders through town hall meetings, emails, written letters, and press releases to the media and local newspapers, and social media
- Communications may also lead to further collaborations, shared resources and referrals, partnerships and providing guidance in tobacco cessation to other community organizations

Frequently Asked Questions

The following are some of the more commonly asked questions or concerns of SUD treatment centers implementing the TTTF program:

Common Leadership Concerns about Implementation

1. Will clients and staff be at risk of being hit by vehicles because they will need to go in the street or across the street to use tobacco?

This concern has been voiced by a surprisingly high number of SUD treatment centers. There is no evidence showing an increase of people being struck by a vehicle when leaving campus grounds to use a tobacco product.

2. Our center passed a smoke-free/tobacco-free policy already but people still use on the grounds all the time. Can these policies be effectively enforced?

Yes, the policies can be enforced. Effective enforcement includes visible, permanent tobacco-free signage prominently displayed inside and outside buildings. Early and often communication with staff and clients about the policy and training all staff, including new staff, on how to talk with a person who is violating the policy is also crucial. Most importantly, it is the responsibility of *all* staff to talk with people who are violating the policy. If only a few people address violations, the policy will not be effective. The enforcement must be shared by all staff.

A center may have to "reboot" and update their existing tobacco-free policy and start from scratch. This implementation guide provides examples to help you implement a sustainable TFW policy.

3. Will neighboring businesses and homeowners complain because tobacco users will go to their property to use tobacco?

This is a realistic concern and one that needs to be discussed months before the implementation of the TFW policy. All neighboring businesses, homeowners, and other possibly impacted parties should be notified of the impending TFW policy and be invited to a town hall meeting or another scheduled meeting. Your plan for education and enforcement should be shared and all attendees should be provided with information on who they should call at your center if clients are found using tobacco products on their property.

4. Won't people stop coming for services?

No, research shows that adopting a TFW policy does not lead to a significant increase in people choosing not to receive mental health[67] or SUD treatment services.[77]

5. Is it legal for residential housing complexes to adopt tobacco-free policies?

Yes. This applies to tobacco use inside private residence, common areas (e.g., courtyards, patios, play areas, pools, laundry facilities, etc.), and other outside areas.

On November 30, 2016, the U.S. Department of Housing and Urban Development (HUD) announced that public housing developments in the U.S. will now be required to provide a smoke-free environment for their residents within the next 18 months. The deadline for public housing developments to transition into being smoke-free was July 31, 2018. More about this recent decision can be found at: https://portal.hud.gov/hudportal/HUD?src=/program_offices/healthy_homes/smokefree2

6. It is a right to smoke. Isn't it against the law to prohibit people from smoking?

Everybody was born a non-tobacco user and people who use tobacco products are not a protected class. There is no constitutional right to use tobacco and therefore prohibiting the use of tobacco products is legal. No one is preventing clients from smoking; the policy only places legal limitations on where smoking can occur; it can no longer occur on center property.

It is the thousands of chemicals, and combinations of the chemicals, that make tobacco products so deadly. The goal of NRT is to deliver nicotine, or the addictive drug that gets people hooked quickly and makes quitting hard, in the safest way – through NRT products. This makes the process of quitting easier, and the NRT products can be tapered down over time. Indeed, for the majority of people, using NRT will have no negative health consequences – tobacco users are already getting nicotine through their tobacco products, and NRT products are designed to give the client a smaller, steadier dose over time than they are already used to.

7. Do staff have to quit using tobacco once the TFW policy is implemented?

No. Typically a TFW policy prohibits the use of tobacco products while on the grounds. Policies may extend to any official work business, whether on or off campus, and may include parking lots, in company and private vehicles, and/or when meeting with a client. A staff can use tobacco products before or after work hours and not be in violation of the policy.

Clinical Concerns

1. Encouraging clients to quit using tobacco will jeopardize their treatment and recovery. Isn't it non-therapeutic to take tobacco away from them?

Many studies have shown that assisting clients to quit tobacco does not jeopardize their treatment or lead to increase substance use, in the long term. In fact, research shows that helping people with a SUD to quit tobacco may decrease depression, anxiety, and stress and decrease relapse rates in substance abusers. It could be said that it is counter-therapeutic to refrain from assisting clients to quit tobacco when research shows that 1 out of every 2 people with a SUD will likely die from a tobacco-related illness.

2. Does prohibiting clients from using tobacco on the grounds negatively impact treatment outcomes?

No. Actually, the opposite is true. Research has shown that people who have a SUD see a decrease in depression, anxiety, stress levels and substance use after they quit using tobacco.[48,62] Associated improvements have shown to have a greater than or equal effect as antidepressants for depressive and anxiety disorders.[67] For people receiving services for chemical dependency, quitting smoking increases the likelihood of long-term abstinence by 25%.[49] However, it is important to recognize that symptoms of withdrawal from nicotine often mimic those of psychological disorders (e.g., increased agitation, anxiety, restlessness) and can be confused as exacerbating psychological conditions. Clients should be educated that these are temporary nicotine withdrawal symptoms that will resolve within 2-4 weeks if they abstain from tobacco use. NRT or combination NRT therapies can help to address some of these withdrawal symptoms and should be used as long as needed to make this critical period easier for the client.

3. Won't clients become violent, combative or aggressive if they cannot smoke on the grounds?

Overall, with an effective communication strategy the vast majority of people accept and understand the TFW policy. After all, it follows what they are used to in other settings (e.g., government buildings, movie theaters). However, there may be instances when a person gets irritated about not being able to use tobacco on the grounds and in these situations staff usually have no trouble reminding clients of the new policy that does not allow smoking on campus. This is also a wonderful opportunity to provide information on treatment services or encourage them to talk to a staff member about resources available to help them quit using tobacco.

Nicotine Replacement Therapy

1. Why should we encourage people to use nicotine replacement therapy? Doesn't nicotine cause cancer and heart attacks?

It is true that tobacco products and NRT (patches, gum, lozenges, inhaler, and nasal spray) contain nicotine. When a person uses NRT, they are getting one chemical into their body – nicotine, which does not cause cancer or heart attacks. When a person uses a tobacco product, they are inhaling or ingesting thousands of chemicals – many which cause cancer and heart attacks. The Surgeon General's 2014 report, *The Health Consequences of Smoking – 50 Years of Progress,* provides a detailed explanation of the hundreds of health complications as a result of smoking.[78]

Electronic Nicotine Delivery Systems

1. You recommend that tobacco-free workplace policies include e-cigarettes. Is the aerosol from the electronic cigarettes/vape pens harmful?

The 2016 Surgeon General's report on *E-Cigarette Use Among Youth and Young Adults* summarizes, "E-cigarette aerosol is not harmless 'water vapor,' although it generally contains fewer toxicants than combustible tobacco products." The aerosol created by e-cigarettes can contain ingredients that are harmful and potentially harmful to the public's health, including: nicotine; ultrafine particles; flavorings such as diacetyl, a chemical linked to serious lung disease; volatile organic compounds such as benzene, which is found in car exhaust; and heavy metals, such as nickel, tin, and lead.[79]

2. Are electronic cigarettes or vape pens an effective NRT?

Electronic cigarettes or vape pens are not regulated or approved by the Food and Drug Administration (FDA) as NRT. For this reason, we do not recommend their use in this manner.

Secondhand Smoking

1. I am not hurting other people if I smoke within my apartment. Why should it matter to others?

Unfortunately, the belief that you do not hurt others when you smoke within your apartment is not true. Tobacco smoke seeps between adjoining units and throughout all areas of buildings through light fixtures, ceiling crawl spaces, cracks in walls, plumbing, shared ventilation, and doorways. The Center for Energy and the Environment found that up to 65% of air within a unit can be lost through leakage to another unit, hallway, or exterior.[80] The 2006 U.S. Surgeon General's report on secondhand smoke also supported the adoption of smoke-free policies in multi-unit housing as the only way to protect residents against involuntary exposure and that "there is no risk-free level of exposure to secondhand smoke."[36]

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Acronyms List

1. APA = American Psychological Association
2. BTCRO = Billy T. Cattan Recovery Outreach
3. CEO = Chief Executive Officer
4. CTTS = Certified Tobacco Treatment Specialist
5. DPP = Direct Purchase Program
6. ED = Executive Director
7. EHR = electronic health record
8. ENDS = electronic nicotine delivery systems
9. ETS = environmental tobacco smoke
10. FDA = Food and Drug Administration
11. FQHC = Federally Qualified Health Center
12. HUD = Housing and Urban Development
13. IT = information technology
14. LMHP = licensed mental health professional
15. MI = Motivational Interviewing
16. NRT = nicotine replacement therapy
17. PAP = Patient Assistant Program
18. QIP = quality improvement plan
19. SAMHSA CSAT = Substance Abuse and Mental Health Services Administration Center for Substance Abuse Treatment
20. SUD = substance use disorder
21. TFW = tobacco-free workplace
22. TTTF = Taking Texas Tobacco Free
23. TUA = tobacco use assessment

Appendices

Appendix A: Tobacco-free Policy
- (1) Santa Maria Hostel tobacco-free campus policy
- (2) Alpha Home tobacco-free campus policy
- (2) Billy T. Cattan Recovery Outreach Center tobacco-free campus policy

Appendix B: E-mail Notifications to Employees
- Santa Maria Hostel e-mail notification

Appendix C: Tobacco-free Workplace Signage Notifications
- Tobacco-free campus signage notifications

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Appendix A: Tobacco-free Policy

TOBACCO FREE WORKPLACE

Santa Maria Hostel is dedicated to improving the health of our patients and communities we serve. The health hazards of smoking and tobacco use are well known. Allowing the use of tobacco products in and around our facilities does not support the image of our organization as a health care leader in the community and does not promote a healthy environment for our clients or employees. Encouraging and assisting our employees, our clients and our visitors to be tobacco free is consistent with our mission to improve the health of the communities we serve.

This Policy applies to all employees of Santa Maria Hostel. It is applicable at all facilities, vehicles and programs.

This prohibition includes but is not limited to cigarettes, cigars, snuff, pipes, chewing tobacco, and any form of electronic smoking devices.

PROCEDURES:

1. Smoking and the use or possession of tobacco products (cigarettes, cigars, chewing tobacco, snuff, pipes, any form of electronic devices, etc.) is prohibited in or on all Santa Maria Hostel owned or leased buildings, grounds, parking lots or vehicles.

2. Smoking in private vehicles on Santa Maria Hostel's owned or leased properties is also not allowed.

3. Employees will not be allowed to smoke or use any tobacco products during their paid work time (including breaks) and are encouraged not to use tobacco products during their unpaid work time (lunch).

4. Employees may not have the smell of tobacco smoke about their persons during work hours or while on company business. In general, employees should not use or consume any substance, the effects or traces of which could interfere with the employee's presentation of a clean and professional appearance to clients, customers and the public in general. Employees may be sent home to change if they are in violation of this policy.

5. Santa Maria Hostel wishes to maintain good relationships with its neighbors, so loitering on or littering (including cigarette butts) on, smoking on, or the use of tobacco products on neighboring property is not permitted.

6. Human resources will post on all job postings, inform all candidates through the hiring process, and inform all new hires at orientation that the organization is a tobacco free workplace.

7. Clients will be informed of the tobacco free policy during the admission and/or pre-admission process.

8. Full compliance with this policy is expected. Employees who violate this policy will be subject to disciplinary procedures according to policy

9. No exceptions to this policy will be granted.

TOBACCO FREE WORKPLACE

Alpha Home is designated as a Tobacco Free Campus for the benefit of the overall health of its clients, employees, contractors, volunteers and visitors.

Smoking and the use or possession of tobacco products, including but not limited to: cigarettes, cigars, chewing tobacco, snuff, pipes, any form of electronic devices, is prohibited in or on all Alpha Home owned or leased buildings, grounds, parking lots and vehicles.

This policy is effective as of July 4, 2019.

If an employee observes a violation of any of the following procedures the employee should respectfully inform the violator that tobacco products are prohibited in or on all Alpha Home owned or leased buildings, grounds, parking lots and vehicles.

PROCEDURES:

1. Smoking in private vehicles on Alpha Home's owned or leased properties is not allowed.

2. Employees will not be allowed to smoke or use any tobacco products during their paid work time (including breaks) and are encouraged not to use tobacco products during their unpaid work time (lunch).

3. Employees may not have the smell of tobacco smoke about their persons during work hours or while on company business. In general, employees should not use or consume any substance, the effects or traces of which could interfere with the employee's presentation of a clean and professional appearance to clients, visitors and the public in general. Employees may be sent home to change if they are in violation of this policy.

4. Alpha Home wishes to maintain good relationships with its neighbors, so loitering on or littering (including cigarette butts) on, smoking on, or the use of tobacco products on neighboring properties is not permitted.

5. Signs will be posted at strategic locations around Alpha Home campuses to notify clients, employees, contractors, volunteers and visitors of this policy.

6. Human resources will post on all job postings, inform all candidates through the hiring process, and inform all new hires at orientation that Alpha Home is a tobacco free workplace.

7. All clients will be given information regarding this policy at intake.

8. Alpha Home contracts with third party vendors and contractors shall contain language enforcing Alpha Home's Tobacco-Free Campus policy.

9. Full compliance with this policy is expected. Clients and employees who are in violation will be subject to disciplinary procedures according to policy.

10. No exceptions to this policy will be granted.

BILLY T. CATTAN
RECOVERY OUTREACH CENTER
Treating Addiction. Repairing Lives.

TOBACCO-FREE FACILITY POLICY

Billy T. Cattan Recovery Outreach (BTCRO) is dedicated to improving the health of our clients and communities we serve. The health hazards of smoking and tobacco use are well known. Tobacco use is the number one cause of preventable illness and death across the nation. Allowing the use of tobacco products in and around our campus does not support the image of our Center as a health care leader in the community and does not promote a healthy environment for our clients or employees. Encouraging and assisting our employees, our clients and our visitors to be tobacco free is consistent with our mission to improve the health of the communities we serve.

SCOPE: This Policy applies to all clients, visitors, contractors, physicians, volunteers and employees of Billy T. Cattan Recovery Outreach. It is applicable at all campuses, facilities, vehicles and programs.

This policy includes but is not limited to cigarettes, cigars, snuff, pipes, chewing tobacco, and any form of electronic smoking devices.

PROCEDURES:

1. Smoking and the use or possession of tobacco products (cigarettes, cigars, chewing tobacco, snuff, pipes, any form of electronic devices, etc.) is prohibited in or on all Billy T. Cattan Recovery Outreach Center, grounds, parking lots or vehicles.

2. Smoking in private vehicles on BTCRO property is also not allowed.

3. Smoke odors at any time are not allowed.

4. BTCRO wishes to maintain good relationships with its neighbors, so loitering on or littering (including cigarette butts) on, smoking on, or the use of tobacco products on neighboring property is not permitted.

5. The Executive Director will inform all new hires at orientation that the organization is a tobacco free workplace.

6. Signs will be posted at strategic locations around BTCRO campuses to notify staff, visitors, contractors, volunteers and clients of this policy.

7. Clients will be informed of the tobacco free policy during the admission and/or pre-admission process. Client information, such as the Client Handbook, pre-admission materials, etc. will include a notice regarding BTCRO tobacco free policies. Alternatives to smoking (Nicotine Replacement Therapy) will be offered clients upon a screening or assessment.

8. All employees are authorized to communicate this policy with courtesy and diplomacy to other employees, contractors, volunteers, clients and visitors.

9. Full compliance with this policy is expected. Employees and Clients/Visitors who violate this policy will be subject to disciplinary procedures according to policy.

10. BTCRO will adopt clinical practices that provide client education and training on health related topics, including the health hazards of tobacco use and information and resources to assist with tobacco cessation.

Addendum Adopted: April 2, 2018

Appendix B: E-mail Notifications to Employees

SANTA MARIA HOSTEL EMAIL NOTIFICATION

Subject: Tobacco Free Campus Reminder

Hello All, and Happy New Year!

As we begin a new year and fresh start, I want to share some more detailed information about the exciting policy changes coming to Santa Maria. **On February 1st, 2019 Santa Maria will become a Tobacco Free Campus** with support provided by the Tobacco Free project in partnership with Integral Care and the University of Houston.

I have attached the Tobacco Free Workplace policy to this email and I strongly encourage all of you to review and become familiar with it. To provide some further clarification about the policy and what it means for you, I am also providing more detailed information below:

- Smoking and the use or possession of tobacco products (cigarettes, cigars, chewing tobacco, snuff, pipes, any form of electronic devices, etc.) is prohibited in or on all Santa Maria Hostel owned or leased buildings, grounds, parking lots or vehicles.
    - NOTE: Transitional housing (HUD, VIEWS, and Sober Living) clients are exempt from this policy in that they are allowed to have tobacco products in their possession. However, congruent with our previous policy, smoking or the use of tobacco products is strictly prohibited on SMH property, parking lots, and vehicles.
- Designated smoking times will no longer be provided for clients or staff at Santa Maria
- Employees will not be allowed to smoke or use any tobacco products during their paid work time (including breaks) and are encouraged not to use tobacco products during their unpaid work time (lunch)
- Employees may not have the smell of tobacco smoke about their persons during work hours or while on company business. In general, employees should not use or consume any substance, the effects or traces of which could interfere with the employee's presentation of a clean and professional appearance to clients, customers and the public in general. Employees may be sent home to change if they are in violation of this policy
- We ask that all individuals do not smoke within visual distance of the property including in front of the buildings, in the parking lot, and on the sidewalk in front of the facilities
- Santa Maria Hostel wishes to maintain good relationships with its neighbors, so loitering on or littering (including cigarette butts) on, smoking on, or the use of tobacco products on neighboring property is not permitted
- While clients will be informed of the tobacco free policy during the admission process, we also encourage you to speak with both current and clients about this policy change

- This policy will be enforced at Santa Maria, on Santa Maria property. If a client uses tobacco products offsite, it should not result in any punitive action for the client. However, it is an opportunity for clinical staff to engage and motivate the client toward non use.
- Full compliance with this policy is expected and appreciated. Employees who violate this policy will be subject to disciplinary procedures according to policy

Mandatory trainings about the Tobacco Free Workplace policy will be provided on **January 9th and January 16th**. Please see the training emails from [insert Training Coordinator name] for further information.

Lastly, we want to make this transition as smooth as possible and to provide staff with the opportunity to make a tobacco quit attempt if they wish to do so. **Starting this week, nicotine replacement therapy (NRT) will be available at no cost to all Santa Maria staff.** Our Santa Maria point of contact for this initiative is [insert Clinic Champion name]. If you are interested in making a quit attempt using the nicotine replacement therapy provided by Santa Maria, please contact her directly. You are also welcome to reach out to her with any questions that arise during this process or about questions specific to the policy.

Thank you for your cooperation and for helping us promote a healthier lifestyle for our workplace and women.

CEO

Appendix C: Tobacco-Free Workplace Signage Notifications

Appendix D: Notification to Community Partners

ALPHA HOME EMAIL NOTIFICATION

Alpha Home is designated as a **Tobacco Free Campus** for the benefit of the overall health of its clients, employees, contractors, volunteers and visitors.

Smoking and the use or possession of tobacco products, including but not limited to: cigarettes, cigars, chewing tobacco, snuff, pipes, any form of electronic devices, is prohibited in or on all Alpha Home owned or leased buildings, grounds, parking lots and vehicles.

This policy is effective as of **July 4, 2019.**

Please read, print, and sign/date a copy of the AH Tobacco Free Policy document (anywhere at the top of document) and **return to Carol or Nangie for your personnel file.

We eagerly anticipate great results for all, but know that there may be a few initial hiccups along the way. If you have any concerns, thoughts or questions, please feel free to contact me at extension 3024.

Thanking you in advance,
Carol

Carol Carroll Kratochvil, LCDC, CTTS
New Client Liaison

ALPHA HOME
Pathway to Recovery Since 1966

The mission of Alpha Home is to offer a pathway of help, hope, and healing through spiritually based drug and alcohol treatment and support.

Appendix E: Tobacco-free Kick Off Event

***Integral Care* Announces New Tobacco Free Workplace Policies** *(Austin) –Integral Care* today announced plans to implement a new tobacco-free policy at all facilities, effective *DATE.* Hospital leaders say the new policy reflects the health system's mission: "We are eliminating tobacco-use on our properties to provide a healthy and safe environment for employees, clients and visitors and to promote positive health behaviors," said Mr. David Evans, Chief Executive Officer at *Integral Care.*

The new policy bans the use of all tobacco products, including cigarettes, cigars, pipes and smokeless tobacco, within all properties owned, leased, or occupied by *Integral Care.* This includes parking lots, agency vehicles, and employees' personal vehicles parked on the premises. Employees are prohibited from using tobacco products during working hours. The US Surgeon General's Office in 1964 declared that smoking is hazardous to health. Yet smoking remains the number one cause of preventable death and disability, according to the Centers for Disease Control & Prevention. *Integral Care* views tobacco-use as a quality concern: "We can no longer turn a blind eye to on-campus smoking when we know that continued tobacco use can cause problems for a clients," said Director of Tobacco Cessation Program, Dr. Singh, "30 minutes exposure to smoke increases the risk of blood clots, slow blood flow to Coronary Arteries, Injures blood vessels and interferes with their repairs, and also kills more than AIDS, cocaine, heroin, alcohol, car accidents, fire and homicide COMBINED." Furthermore, three-fourths of all tobacco-users say they want to quit. But the *Integral Care* medical director recognizes the challenges of breaking the addiction to nicotine and respects an individual's quitting process. "We are not telling anyone, 'you must quit smoking.'" said Dr. Van Norman, Director of Medical Services "We are saying, 'Don't use tobacco on our campus.' While you are a client or visitor at this center, we can suggest ways to ease nicotine withdrawal symptoms. And if you are ready to quit, we have trained professionals and community partners who can help you."

Integral Care hopes center employees will help inform visitors and patients about the new policy, said Mr. Evans, CEO. "This will not be easy," he said, "but it's central to our continuing efforts to make an excellent place to work and to receive health care." In implementing the new tobacco ban, the agency plans to offer symptom relief or tobacco-cessation treatment to interested staff, visitors and clients.

Santa Maria Hostel Kick-Off Event Press Release

UH Program Helps Houston Recovery Centers Go Tobacco Free

Centers for Disease Control: Quitting can Improve Mental Health and Substance Use Recovery

By Laurie Fickman (mailto:lafickman@uh.edu) 713-743-8454

January 30, 2019

Please note – Lorraine Reitzel and Angela Morgan are available for interviews by advance request. To schedule an interview please contact Laurie Fickman at 713-743-8454.

HOUSTON, Jan. 30 – Angela Morgan, a family coach at Santa Maria Hostel (http://www.santamariahostel.org/), Texas' largest multi-site residential and outpatient addiction recovery center for women and their children, has been a cigarette smoker for 29 years. On February 1, she's done.

"I had been thinking about quitting over the years, but what really got me to propel forward was two years ago I lost my brother, a smoker, at age 40, and then last year on the anniversary of his death - the very same day - my father had a heart attack. He was a smoker too," said Morgan. Though he survived, she was terrified.

Morgan's target date is the day all Santa Maria Hostel sites go tobacco free, as part of the University of Houston's Taking Texas Tobacco Free (https://www.takingtexastobaccofree.com/), a prevention program reducing the incidence of tobacco-related cancers among Texans by assisting community behavioral health centers across the state to adopt and implement comprehensive tobacco-free campus policies. The organization is funded by the Cancer Prevention and Research Institute of Texas and partners with Integral Care of Austin/Travis

People with mental and substance use disorders are approximately twice as likely as the general population to smoke cigarettes and are more likely to die from smoking-related illness than from their mental and substance use disorders.

Lorraine Reitzel, associate professor of health at the UH College of Education and head of the UH Social Determinants/Health Disparities Lab, is changing how tobacco use is addressed within the substance use community.

County and the University of Houston's HEALTH Research Institute (https://healthuh.com/) on these projects.

"Our aim is to change the landscape of how tobacco use is addressed within substance use treatment centers and other community agencies that serve their clientele," said Lorraine Reitzel, associate professor of health at the UH College of Education and head of the UH Social Determinants/Health Disparities Lab (http://www.lorrainereitzel.com).

It's no small problem. According to the CDC, people with behavioral health conditions such as major depression, schizophrenia, and alcohol or drug dependence are more likely than those without such conditions to smoke and to smoke more heavily; in addition, they account for nearly half of all tobacco-related deaths each year. Texas has a higher rate of death attributable to smoking relative to the remainder of the U.S., at 273 per 100,000 adults.

At the Santa Maria Hostel, quitting smoking is something to celebrate, and that's what they will do.

What: Kickoff for Santa Maria Hostel Goes Tobacco Free. Among educational materials available on site will be a carbon monoxide monitor to measure the amount of CO2 in your lungs.

When/Where: Friday Feb. 1. Two Santa Maria locations and times:
10 a.m. – noon, Jacquelyn House, 2005 Jacquelyn Drive, Houston, 77055
1 p.m. – 3 p.m., Bonita House, 2605 Parker Road, Houston 77093

ABOUT TAKING TEXAS TOBACCO FREE

The University of Houston's Taking Texas Tobacco Free is a multicomponent, tobacco free workplace program that has been implemented in 22 Texas Local Mental Health Authorities (LMHAs). The mission is to promote wellness among Texans by partnering with healthcare organizations to build capacity for system-wide, sustainable initiatives that will reduce tobacco use and secondhand smoke exposure among employees, consumers, and visitors.

ABOUT SANTA MARIA HOSTEL

The mission of Santa Maria Hostel is to empower women and their families to lead healthy, successful, productive and self-fulfilling lives. Santa Maria began in 1957 and today is one of Texas' largest multi-site residential and outpatient addiction treatment centers for women, and one of the only programs in the state where a mother can bring her children with her while she accesses residential treatment. In addition, we provide a full continuum of services to meet each woman or family where they are at on their recovery journey, from community-based prevention and intervention programs through long term recovery support, housing, and aftercare. By offering vital services and life changing support, Santa Maria offers a pathway to success through recovery. From recovery from addiction to recovering from homelessness, incarceration, abuse and other trauma, Santa Maria has the experience and compassion to offer a hand up, change lives, and heal families.

Categories: Health (../../categories/health.php)

Appendix F: Permanent Signage

Appendix G: Surveillance Checklist

Tobacco-free Campus Surveillance Checklist

Reviewer: Please walk the grounds and note people (staff, security, visitors, clients) who may be actively using tobacco and cigarette butts on ground – note areas with high concentration of litter; take notice of signage or lack thereof. Please take the time to talk with staff about enforcing the tobacco-free policy and assessing and offering cessation services to clients.

Date of scan: _____ Name of reviewer: _____

Time scan took place: _____

Address and name of facility: _____

Tobacco Use on Premise

Were people using tobacco products on grounds at time of visit? □ Yes □ No

If yes, indicate who was using (or who you believe they may be):

□ Integral Care staff □ Security staff □ Client □ Visitor □ 3rd party vendor

Are informational cards readily available to provide to people who are using tobacco products on the grounds?

□ Yes □ No

Are cigarette butts found lying on the ground? □ Yes □ No

If yes, list the locations (take photos of litter):

Tobacco-free Signage

Are tobacco-free signs visibly displayed outside on the grounds? □ Yes □ No

Are tobacco-free signs damaged or vandalized in any manner? □ Yes □ No

If Yes, list extent of damage (take photo of damage):

Are tobacco-free signs visibly displayed inside building(s)? □ Yes □ No

Staff Interactions (talk to two or three staff at facility)

Do employees comply with tobacco-free campus policy all the time? □ Yes □ No

If no, how often do staff not comply? □ Sometimes □ Often □ All the time

Are employee's supervisors notified when an employee violates policy? □ Yes □ No

Do clients comply with tobacco-free campus policy all the time? □ Yes □ No

If no, how often do clients not comply? □ Sometimes □ Often □ All the time

Are clients educated on the policy and respectfully asked to comply with policy? □ Yes □ No

Are clients provided an educational card when observed using tobacco? □ Yes □ No

Are contracted vendors educated on the policy and respectfully asked to comply with policy? □ Yes □ No

Are contracted vendors provided an educational card when observed using tobacco? □ Yes □ No

Tobacco Cessation

Are clients provided information on tobacco-free campus policy during Intake? □ Yes □ No

Are employees familiar with Integral Care's Tobacco Cessation Plan on the Internet? □ Yes □ No

Can employees describe the process in which clients can obtain NRT? □ Yes □ No

Are employees familiar with the process in which employees can obtain NRT to quit? □ Yes □ No

Are tobacco cessation materials available to: employees? □ Yes □ No clients? □ Yes □ No

Appendix H: Policy Acknowledgement

Employee Tobacco-free Policy Acknowledgement

Made effective by the date of acknowledgement, I have received an electronic copy of the Drug, Alcohol and Tobacco Free Workplace Policies. I also acknowledge that the provisions of these Policies are part of the terms and conditions of my employment with Integral Care and that I agree to abide by them.

03.12 BOARD OF TRUSTEES POLICY

Title: Tobacco Free Work Place Policy

Section: Internal Management

Cross Reference: OP 03.26

PURPOSE

The purpose of this policy is to make Integral Care facilities tobacco free for the benefit of the overall health of its clients, employees, contractors, volunteers and visitors. This includes all tobacco products as well electronic nicotine delivery devices.

As the local authority and provider of behavioral health and developmental disability services, Integral Care is committed to healthy and safe environments that promote positive, healthy behaviors.

POLICY

It is Integral Care's policy to enforce tobacco free initiatives for the health and well-being of its clients, employees, contractors, volunteers and visitors at Integral Care facilities and establish the means to do so. These initiatives include, but are not limited to the following:

* The development and implementation of appropriate Integral Care procedures relating to these initiatives;

* Providing assistance for Integral Care clients and staff to become tobacco free through tobacco cessation education, American Public Health Service approved treatment(s) and support;

* Increasing Integral Care's involvement in treating nicotine addiction; and

* Coordinating and cooperating with local government in the development and execution of a Tobacco Free Workplace Plan.

Effective Date: July 29, 2010

Revised Date: January 30, 2014

Approved: Matt Snapp

Signature: _____

Appendix I: Tobacco Use Assessment and Contemplation Ladder

Montrose Center

Peer Services Process
Re-entry Documentation
20.5.2 TOBACCO CESSATION SERVICES ENROLLMENT APPLICATION

Please print clearly **Date:** ☐☐/☐☐/☐☐☐☐

Name:
☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐
First MI Last

Preferred Name:
☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Home Address:
☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

City: ☐☐☐☐☐☐☐☐☐☐☐ State: ☐☐ Zip: ☐☐☐☐☐

May we send you mail to this address? ☐ yes ☐ no

Home Phone: (☐☐☐)☐☐☐-☐☐☐☐

Cell Phone:(☐☐☐)☐☐☐-☐☐☐☐ May we text reminders about appts? ☐ yes ☐ no

Email:☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐@☐☐☐☐
☐☐☐☐☐☐☐☐☐☐☐.☐☐☐

May we email you about appointments? ☐ yes ☐ no May we add you to our e-newsletter list? ☐ yes ☐ no

Driver's License #: ☐☐☐☐☐☐☐☐☐☐ State: ☐☐

Household Income $☐☐☐,☐☐☐

Number of people in the household: ________ How many of these are dependent children? _____

Date of Birth: ☐☐/☐☐/☐☐☐☐ **Sex at birth:** ☐ Male ☐ Female ☐ Intersex

Gender: ☐ Male ☐ Female ☐ Transgender Female/Feminine ☐ Transgender Male/Masculine ☐ Genderqueer
☐ Pangender ☐ Other: ________________ **Pronoun:** ☐ He/Him ☐ She/Her ☐ Ze/Hir ☐ They/Them

Orientation: ☐ Asexual ☐ Bisexual ☐ Gay ☐ Gay/Lesbian ☐ Heterosexual/Straight ☐ Lesbian
☐ Pansexual ☐ Queer ☐ Questioning ☐ Don't Know ☐ Other: ________________

Ethnicity (optional - for statistical information only):
Are you of Spanish/Latino(a) origin? ☐ yes ☐ no ☐ Decline to Answer
If yes, ☐ Mexican, Mexican American, Chicano/a ☐ Cuban ☐ Puerto Rican ☐ Other/Multi Hispanic, Latino/a or Spanish origin

Race (optional - for statistical information only):
☐ American Indian or Alaska Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian/PI
☐ White ☐ Other, explain: ________________ ☐ Decline to Answer
If Asian: ☐ Asian Indian ☐ Chinese ☐ Filipino ☐ Japanese ☐ Korean ☐ Vietnamese ☐ Other/Multi Asian

Primary Physician/Clinic Name:____

City:________________________ State:______ Phone:(_____) _____ - __________

Known drug allergies:____

Emergency Contact Name:________________________ Relation:________________

Phone:(_____) _____ - __________ Email:________________@________________

the Montrose Center 3/16, 3/19

Peer Services Process
Re-entry Documentation

About Your Tobacco Use

	Typical Use Per Day	Current Use Per Day	Year started (or age)	Year quit (or age)	Quit Duration	Brand
Cigarettes						
Chewing Tobacco						
Dip or Snuff						
Pipes						
Cigars						
E-cigarettes/ Vape						
Other: (Specify)						

Have you quit tobacco use for greater than 24 hours? ☐ yes ☐ no If ***yes,*** how many times?_____

What is the longest period of voluntary abstinence from tobacco?_____

When was the most recent serious attempt to quit, how long did attempt last?_____

_____

What methods have you used to stop tobacco use? ☐ cutting back ☐ abstinence/"cold turkey"
☐ support groups ☐ online coaching/chat ☐ individual coaching ☐ nicotine gum
☐ nicotine lozenges ☐ nicotine patches ☐ Chantix (varenicline) ☐ Wellbutrin (bupropion)
☐ 1:1 counseling/therapy ☐ hypnosis ☐ meditation ☐ exercise ☐ other:_____

What was helpful and/or not helpful to you?_____

What are your reasons for wanting to quit?_____

_____

What behaviors, stressors or triggers cause a craving for you?_____

_____

If living with a partner, does your partner use tobacco products? ☐ yes ☐ no
If ***yes,*** how often and how much?_____

Does anyone else in your life or household use tobacco products? ☐ yes ☐ no
If ***yes,*** how often and how much?_____

During a typical weekday, how often do you come in contact with a tobacco user?_____

During a typical weekend, how often do you come in contact with a tobacco user?_____

What have medical professionals told you about your need to quit smoking/tobacco use?_____

_____

Are you currently taking any medications and/or NRT to help you quit tobacco use? If so, which ones?

_____

_____

ASSESSMENT ADDENDUM (To be completed only if the client has not received a formal intake assessment.)

Mental Health History

How many times have you been treated for any psychological or emotional problems?

In the hospital_____ Outpatient or private patient_____ Court ordered? ☐ yes ☐ no

Past psychiatric experience

Where	Month/Year	How Long	Was this helpful?	Psychiatric or Drug Related

Have you received counseling from (check all that apply)* ☐ psychiatrist ☐ psychologist
☐ psychotherapist/counselor ☐ drug counselor minister/priest
☐ other (describe):_____

Have you ever had a period of at least two weeks when you felt down, depressed or hopeless (experienced a time or little interest or pleasure in doing things)? ☐ yes ☐ no

Alcohol and Drug Use Screening [AUDIT C]

When was the last time you had a drink containing alcohol? _____ How many drinks?_____

In the PAST YEAR, how often have you used any prescription medications just for the feeling, more than prescribed or that were not prescribed for you?

☐ Never ☐ Less than monthly ☐ Monthly ☐ Weekly ☐ Daily or almost daily

Which medication(s)?_____

When was the last time you used?_____How much did you take?_____

In the PAST YEAR, how often have you used any drugs including marijuana, cocaine or crack, heroin, methamphetamine (crystal meth), hallucinogens, ecstasy/MDMA?

☐ Never ☐ Less than monthly ☐ Monthly ☐ Weekly ☐ Daily or almost daily

Which drug(s)?_____

When was the last time you used?_____How much did you use?_____

In the PAST 3 MONTHS,

have you tried and failed to control, cut down or stop drinking or using drugs/medications? ☐ yes ☐ no
has anyone expressed concern about your drinking or drug/medication use? ☐ yes ☐ no

Have you ever had any of the following happen as a result of drinking or drug/medication use?

☐ lost a job ☐ overdosed ☐ lost time ☐ legal consequences (DWI, PI, jail, probation)
☐ injected drugs with needles ☐ health problems ☐ mental health problems

In the past year, has your alcohol/drug usage: ☐ Increased ☐ Decreased ☐ Remained the same

Social and Other Factors

How much social support do you currently have? _____

_____

How are relationships in family? How is home environment?_____

_____

Do you work? Are you a student? How are those experiences for you?_____

_____

How is your financial health? Does it impact your tobacco use?_____

_____

What do you do to relax, cope with stressful situations?_____

_____

Medical History

Have you experienced or been diagnosed with the following?

☐ Diabetes ☐ Hypertension ☐ Heart Problems
☐ Seizures ☐ Kidney Problems ☐ Other: _____

Are you pregnant? ☐ yes ☐ no

Which medications are client taking?_____

_____

Denton County MHMR Center

Cigarette smoking status:
0 Current every day smoker
0 Current some days smoker
0 Former smoker
0 Never smoker
0 Smoker, current status unknown
0 Unknown if every smoked

Do you live with tobacco user(s)?
0 Yes 0 No

Do you butt out and relight?
0 Yes 0 No

If so, how many times per day? _____

Any tobacco use status:
0 Current user 0 Past User 0 Never used

0 Currently use cigarettes
0 Currently use pipe
0 Currently use cigars
0 Currently use smokeless
0 Currently use other-e-cig/vape, etc.

0 Previously used cigarettes
0 Previously used pipe
0 Previously used cigars
0 Previously used smokeless
0 Previously used other-e-cig/vape, etc.

If other please specify: _____

Fagerström Test:
1) How soon after you wake up do you smoke your first cigarette?
   a) Within 5 minutes (3 points)
   b) 6-30 minutes (2 points)
   c) 31-60 minutes (1 point)
   d) After 60 minutes (0 points)
2) Do you find it difficult to refrain from smoking in places where it is forbidden?
   a) Yes (1 point)
   b) No (0 points)
3) Which cigarette would you hate most to give up?
   a) The first one in the morning (1 point)
   b) All others (0 points)
4) How many cigarettes per day do you smoke?
   a) 10 or fewer (0 points)
   b) 11-20 (1 point)
   c) 21-30 (2 points)
   d) 31 or more (3 points)
5) Do you smoke more frequently during the first hours after waking than during the rest of the day?
   a) Yes (1point)
   b) No (0 points)
6) Do you smoke if you are so ill that you are in bed most of the day?
   a) Yes (1 point)
   b) No (0 points)

Proposed Scoring Cut Offs:
0-2 very low
3-4 Low
5 Medium
6-7 High (Heavy)
8-10 Very High

How many years have you been using tobacco products? _____

Type/amount of tobacco used per day: _____

Have you ever attempted to quit? 0 Yes 0 No **Approximate Date of last quit attempt**: _____

How many times have you attempted to quit tobacco? _____

Methods used in previous quit attempts:
0 Acupuncture 0 Counseling 0 Cognitive Behavioral Therapy 0 Hypnotherapy
0 Over the Counter Medication 0 Prescription Medication 0 Without Assistance (aka Cold Turkey)
0 If Other, please specify: _____

Have you ever used Nicotine Replacement Therapy products? 0 Yes 0 No

If yes, what products: _____

Readiness to quit: 0 Not interested in quitting 0 Thinking about quitting within next 30 days
0 Ready to quit
Quit Date (if ready to quit): _____

Referrals: 0 Denton County Tobacco Cessation 0 Provided Quit Smoking Brochure(s)
0 Quitline (1-877-YES-QUIT) 0 No Referral
0 If Other, please specify: _____

Signature line indicates last line of report

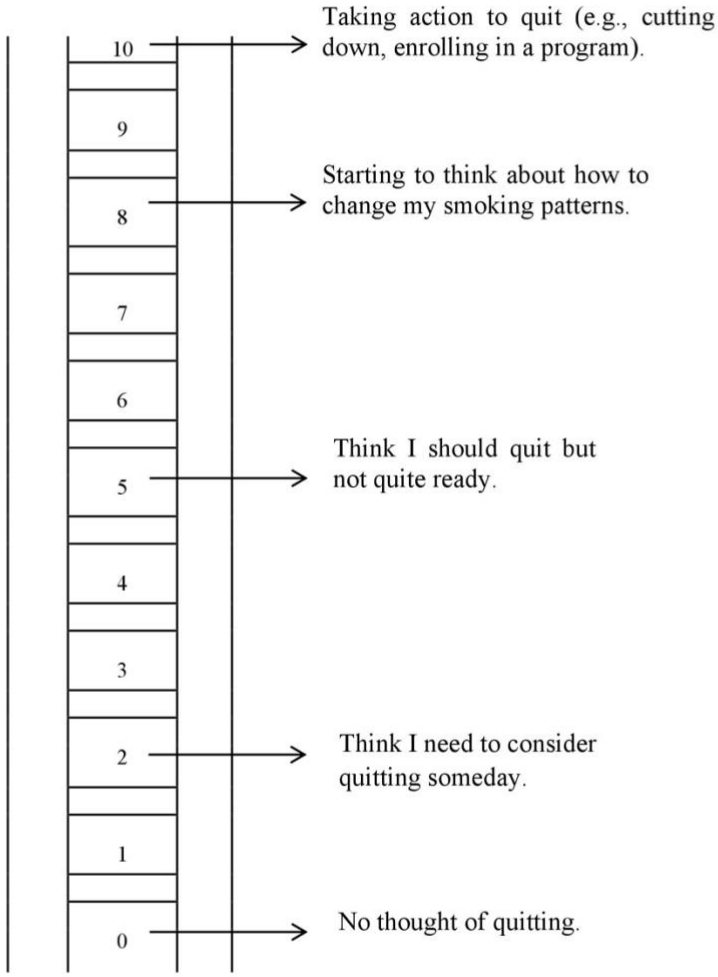
Staff Name ID# _____ _____

Staff Name, Credentials Staff ID Signature Date

Report Run On: _____

Contemplation Ladder – Tobacco (English)

Each rung on this ladder represents where various smokers are in their thinking about quitting. If you have smoked in the last month, please indicate the number that indicates where you are now.



Appendix J: Myths & Facts Handout

Myths & Facts About Quitting Tobacco

Myth #1: "Tobacco helps me deal with my anxiety and stress. If I quit smoking, they will get worse!"
This is probably the most common myth about smoking! Smoking cigarettes is very harmful to our bodies and can actually make anxiety much worse. And while it's true that smoking a cigarette might give you the feeling of temporary relief from anxiety, it's not a long-term way to deal with anxiety.

Of course, it's natural to feel anxious when it comes to quitting tobacco and anxiety is the most common symptom of nicotine withdrawal. Nicotine replacement therapy helps reduce anxiety caused by nicotine withdrawal. When you quit tobacco, talk to your health care professional about nicotine replacement therapy and other healthy ways to cope with anxiety, like exercising or deep breathing.

Myth #2: "I'm too old to quit. I've already done too much damage to my body so there's no use to quitting now."

You are never too old to quit smoking and it's never too late to quit. Remember, there are many health benefits to quitting smoking. You'll even start to notice health benefits within a day of smoking your last cigarette, like lower blood pressure and lower levels of carbon monoxide in your bloodstream. Be sure to watch the video on "Benefits of Quitting" to learn more about the many benefits of quitting smoking.

Myth #3: "I am trying to recover from drug or alcohol abuse. I shouldn't quit smoking now, it might make my recovery harder to achieve."

We know how much hard work it takes to recover from substance addition. Did you know that quitting smoking actually increases your chances for long term sobriety by 25%? Continuing to smoke can act as a trigger or temptation for other substance use and can make your recovery harder. So, quitting smoking at the same time you're recovering from substance addiction can actually make recovery easier.

Myth #4: "If nicotine is in tobacco products, why would I use medication that has nicotine in it? Won't that give me cancer too?"

The nicotine in tobacco causes addiction. Other than being addictive, nicotine has few negative health effects. It may raise your heart rate and blood pressure a little, but other than that, it doesn't really harm your body. Nicotine does not cause cancer. The thousands of other chemicals found in tobacco are what's harmful to your health.

Nicotine replacement therapy helps reduce withdrawal symptoms, which makes it easier to quit. There's only a small chance someone will become addicted to nicotine replacement therapy.

We know quitting tobacco is hard and may feel overwhelming. But with the right resources and support, you can do it. For more resources, please visit our website at takingtexastobaccofree.com.

Appendix K: Medications List and Interaction Document

DRUG INTERACTIONS WITH TOBACCO SMOKE

Many interactions between tobacco smoke and medications have been identified. Note that in most cases it is the tobacco smoke—not the nicotine—that causes these drug interactions. Tobacco smoke interacts with medications through pharmacokinetic (PK) and pharmacodynamic (PD) mechanisms. PK interactions affect the absorption, distribution, metabolism, or elimination of other drugs, potentially causing an altered pharmacologic response. The majority of PK interactions with smoking are the result of induction of hepatic cytochrome P450 enzymes (primarily CYP1A2). PD interactions alter the expected response or actions of other drugs. The amount of tobacco smoking needed to have an effect has not been established, and the assumption is that any smoker is susceptible to the same degree of interaction. The most clinically significant interactions are depicted in the shaded rows.

DRUG/CLASS	MECHANISM OF INTERACTION AND EFFECTS
Pharmacokinetic Interactions	
Alprazolam (Xanax)	▪ Conflicting data on significance, but possible ↓ plasma concentrations (up to 50%); ↓ half-life (35%).
Bendamustine (Treanda)	▪ Metabolized by CYP1A2. Manufacturer recommends using with caution in smokers due to likely ↓ bendamustine concentrations, with ↑ concentrations of its two active metabolites.
Caffeine	▪ ↑ Metabolism (induction of CYP1A2); ↑ clearance (56%). Caffeine levels likely ↑ after cessation.
Chlorpromazine (Thorazine)	▪ ↓ Area under the curve (AUC) (36%) and serum concentrations (24%). ▪ ↓ Sedation and hypotension possible in smokers; smokers may require ↑ dosages.
Clopidogrel (Plavix)	▪ ↑ Metabolism (induction of CYP1A2) of clopidogrel to its active metabolite. ▪ Clopidogrel's effects are enhanced in smokers (≥10 cigarettes/day): significant ↑ platelet inhibition, ↓ platelet aggregation; while improved clinical outcomes have been shown, may also ↑ risk of bleeding.
Clozapine (Clozaril)	▪ ↑ Metabolism (induction of CYP1A2); ↓ plasma concentrations (18%). ▪ ↑ Levels upon cessation may occur; closely monitor drug levels and reduce dose as required to avoid toxicity.
Erlotinib (Tarceva)	▪ ↑ Clearance (24%); ↓ trough serum concentrations (2-fold).
Flecainide (Tambocor)	▪ ↑ Clearance (61%); ↓ trough serum concentrations (25%). Smokers may need ↑ dosages.
Fluvoxamine (Luvox)	▪ ↑ Metabolism (induction of CYP1A2); ↑ clearance (24%); ↓ AUC (31%); ↓ plasma concentrations (32%). ▪ Dosage modifications not routinely recommended but smokers may need ↑ dosages.
Haloperidol (Haldol)	▪ ↑ Clearance (44%); ↓ serum concentrations (70%).
Heparin	▪ Mechanism unknown but ↑ clearance and ↓ half-life are observed. Smoking has prothrombotic effects. ▪ Smokers may need ↑ dosages due to PK and PD interactions.
Insulin, subcutaneous	▪ Possible ↓ insulin absorption secondary to peripheral vasoconstriction; smoking may cause release of endogenous substances that cause insulin resistance. ▪ PK & PD interactions likely not clinically significant; smokers may need ↑ dosages.
Irinotecan (Camptosar)	▪ ↑ Clearance (18%); ↓ serum concentrations of active metabolite, SN-38 (~40%; via induction of glucuronidation); ↓ systemic exposure resulting in lower hematologic toxicity and may reduce efficacy. ▪ Smokers may need ↑ dosages.
Mexiletine (Mexitil)	▪ ↑ Clearance (25%; via oxidation and glucuronidation); ↓ half-life (36%).
Olanzapine (Zyprexa)	▪ ↑ Metabolism (induction of CYP1A2); ↑ clearance (98%); ↓ serum concentrations (12%). ▪ Dosage modifications not routinely recommended but smokers may need ↑ dosages.
Propranolol (Inderal)	▪ ↑ Clearance (77%; via side-chain oxidation and glucuronidation).
Ropinirole (Requip)	▪ ↓ Cmax (30%) and AUC (38%) in study with patients with restless legs syndrome. ▪ Smokers may need ↑ dosages.
Tacrine (Cognex)	▪ ↑ Metabolism (induction of CYP1A2); ↓ half-life (50%); serum concentrations 3-fold lower. ▪ Smokers may need ↑ dosages.
Theophylline (Theo Dur, etc.)	▪ ↑ Metabolism (induction of CYP1A2); ↑ clearance (58–100%); ↓ half-life (63%). ▪ Levels should be monitored if smoking is initiated, discontinued, or changed. Maintenance doses are considerably higher in smokers. ▪ ↑ Clearance with second-hand smoke exposure.
Tricyclic antidepressants (e.g., imipramine, nortriptyline)	▪ Possible interaction with tricyclic antidepressants in the direction of ↓ blood levels, but the clinical significance is not established.
Tizanidine (Zanaflex)	▪ ↓ AUC (30-40%) and ↓ half-life (10%) observed in male smokers.
Warfarin	▪ ↑ Metabolism (induction of CYP1A2) of R-enantiomer; however, S-enantiomer is more potent and effect on INR is inconclusive. Consider monitoring INR upon smoking cessation.
Pharmacodynamic Interactions	
Benzodiazepines (diazepam, chlordiazepoxide)	▪ ↓ Sedation and drowsiness, possibly caused by nicotine stimulation of central nervous system.
Beta-blockers	▪ Less effective antihypertensive and heart rate control effects; possibly caused by nicotine-mediated sympathetic activation. ▪ Smokers may need ↑ dosages.
Corticosteroids, inhaled	▪ Smokers with asthma may have less of a response to inhaled corticosteroids.
Hormonal contraceptives	▪ ↑ Risk of cardiovascular adverse effects (e.g., stroke, myocardial infarction, thromboembolism) in women who smoke and use oral contraceptives. Ortho Evra patch users shown to have 2-fold ↑risk of venous thromboembolism compared to oral contraceptive users, likely due to ↑ estrogen exposure (60% higher levels). ▪ ↑ Risk with age and with heavy smoking (≥15 cigarettes per day) and is quite marked in women ≥35 years old.
Opioids (propoxyphene, pentazocine)	▪ ↓ Analgesic effect; smoking may ↑ the metabolism of propoxyphene (15–20%) and pentazocine (40%). Mechanism unknown. ▪ Smokers may need ↑ opioid dosages for pain relief.

Adapted and updated, from Zevin S, Benowitz NL. Drug interactions with tobacco smoking. *Clin Pharmacokinet* 1999;36:425–438.

Pharmacologic Product Guide: FDA-Approved Medications for Smoking Cessation

Rx for Change

	Nicotine Replacement Therapy (NRT) Formulations					Bupropion SR	Varenicline
	Gum	Lozenge	Transdermal Patch	Nasal Spray	Oral Inhaler		
Prodmc	**Nicorette**[1], **ZONNIC**[2], **Generic** OTC 2 mg, 4 mg original, cinnamon, fruit, mint	**Nicorette Lozenge,**[1] **Nicorette Mini Lozenge,**[1] **Generic** OTC 2 mg, 4 mg; cherry, mint	**NicoDerm CQ**[1], **Generic** OTC (NicoDerm CQ, generic) Rx (generic) 7 mg, 14 mg, 21 mg (24-hr release)	**Nicotrol NS**[3] Rx Metered spray 10 mg/mL aqueous solution	**Nicotrol Inhaler**[3] Rx 10 mg cartridge delivers 4 mg inhaled vapor	**Zyban**[1], **Generic** Rx 150 mg sustained-release tablet	**Chantix**[3] Rx 0.5 mg, 1 mg tablet
Precautions	▪ Recent (≤ 2 weeks) myocardial infarction ▪ Serious underlying arrhythmias ▪ Serious or worsening angina pectoris ▪ Temporomandibular joint disease ▪ Pregnancy[4] and breastfeeding ▪ Adolescents (<18 years)	▪ Recent (≤ 2 weeks) myocardial infarction ▪ Serious underlying arrhythmias ▪ Serious or worsening angina pectoris ▪ Pregnancy[4] and breastfeeding ▪ Adolescents (<18 years)	▪ Recent (≤ 2 weeks) myocardial infarction ▪ Serious underlying arrhythmias ▪ Serious or worsening angina pectoris ▪ Pregnancy[4] (Rx formulations, category D) and breastfeeding ▪ Adolescents (<18 years)	▪ Recent (≤ 2 weeks) myocardial infarction ▪ Serious underlying arrhythmias ▪ Serious or worsening angina pectoris ▪ Underlying chronic nasal disorders (rhinitis, nasal polyps, sinusitis) ▪ Severe reactive airway disease ▪ Pregnancy[4] (category D) and breastfeeding ▪ Adolescents (<18 years)	▪ Recent (≤ 2 weeks) myocardial infarction ▪ Serious underlying arrhythmias ▪ Serious or worsening angina pectoris ▪ Bronchospastic disease ▪ Pregnancy[4] (category D) and breastfeeding ▪ Adolescents (<18 years)	▪ Concomitant therapy with medications/conditions known to lower the seizure threshold ▪ Hepatic impairment ▪ Pregnancy[4] (category C) and breastfeeding ▪ Adolescents (<18 years) **Warning:** ▪ BLACK-BOXED WARNING for neuropsychiatric symptoms[5] **Contraindications:** ▪ Seizure disorder ▪ Concomitant bupropion (e.g., Wellbutrin) therapy ▪ Current or prior diagnosis of bulimia or anorexia nervosa ▪ Simultaneous abrupt discontinuation of alcohol or sedatives/benzodiazepines ▪ MAO inhibitors in preceding 14 days; concurrent use of reversible MAO inhibitors (e.g., linezolid, methylene blue)	▪ Severe renal impairment (dosage adjustment is necessary) ▪ Pregnancy[4] (category C) and breastfeeding ▪ Adolescents (<18 years) **Warning:** ▪ BLACK-BOXED WARNING for neuropsychiatric symptoms[5]
Dosing	*1st cigarette ≤30 minutes after waking:* 4 mg *1st cigarette >30 minutes after waking:* 2 mg Weeks 1–6: 1 piece q 1–2 hours Weeks 7–9: 1 piece q 2–4 hours Weeks 10–12: 1 piece q 4–8 hours ▪ Maximum, 24 pieces/day ▪ Chew each piece slowly ▪ Park between cheek and gum when peppery or tingling sensation appears (~15–30 chews) ▪ Resume chewing when tingle fades ▪ Repeat chew/park steps until most of the nicotine is gone (tingle does not return; generally 30 min) ▪ Park in different areas of mouth ▪ No food or beverages 15 minutes before or during use ▪ Duration: up to 12 weeks	*1st cigarette ≤30 minutes after waking:* 4 mg *1st cigarette >30 minutes after waking:* 2 mg Weeks 1–6: 1 lozenge q 1–2 hours Weeks 7–9: 1 lozenge q 2–4 hours Weeks 10–12: 1 lozenge q 4–8 hours ▪ Maximum, 20 lozenges/day ▪ Allow to dissolve slowly (20–30 minutes for standard; 10 minutes for mini) ▪ Nicotine release may cause a warm, tingling sensation ▪ Do not chew or swallow ▪ Occasionally rotate to different areas of the mouth ▪ No food or beverages 15 minutes before or during use ▪ Duration: up to 12 weeks	*>10 cigarettes/day:* 21 mg/day x 4–6 weeks 14 mg/day x 2 weeks 7 mg/day x 2 weeks *≤10 cigarettes/day:* 14 mg/day x 6 weeks 7 mg/day x 2 weeks ▪ May wear patch for 16 hours if patient experiences sleep disturbances (remove at bedtime) ▪ Duration: 8–10 weeks	1–2 doses/hour (8–40 doses/day) One dose = 2 sprays (one in **each** nostril); each spray delivers 0.5 mg of nicotine to the nasal mucosa ▪ Maximum – 5 doses/hour or – 40 doses/day ▪ For best results, initially use at least 8 doses/day ▪ Do not sniff, swallow, or inhale through the nose as the spray is being administered ▪ Duration: 3–6 months	6–16 cartridges/day Individualize dosing; initially use 1 cartridge q 1–2 hours ▪ Best effects with continuous puffing for 20 minutes ▪ Initially use at least 6 cartridges/day ▪ Nicotine in cartridge is depleted after 20 minutes of active puffing ▪ Inhale into back of throat or puff in short breaths ▪ Do NOT inhale into the lungs (like a cigarette) but "puff" as if lighting a pipe ▪ Open cartridge retains potency for 24 hours ▪ No food or beverages 15 minutes before or during use ▪ Duration: 3–6 months	150 mg po q AM x 3 days, then 150 mg po bid ▪ Do not exceed 300 mg/day ▪ Begin therapy 1–2 weeks **prior** to quit date ▪ Allow at least 8 hours between doses ▪ Avoid bedtime dosing to minimize insomnia ▪ Dose tapering is not necessary ▪ Duration: 7–12 weeks, with maintenance up to 6 months in selected patients	Days 1–3: 0.5 mg po q AM Days 4–7: 0.5 mg po bid Weeks 2–12: 1 mg po bid ▪ Begin therapy 1 week **prior** to quit date ▪ Take dose after eating and with a full glass of water ▪ Dose tapering is not necessary ▪ Dosing adjustment is necessary for patients with severe renal impairment ▪ Duration: 12 weeks; an additional 12-week course may be used in selected patients

	Nicotine Replacement Therapy (NRT) Formulations					Bupropion SR	Varenicline
	Gum	Lozenge	Transdermal Patch	Nasal Spray	Oral Inhaler		
Adverse Effects	▪ Mouth/jaw soreness ▪ Hiccups ▪ Dyspepsia ▪ Hypersalivation ▪ Effects associated with incorrect chewing technique: – Lightheadedness – Nausea/vomiting – Throat and mouth irritation	▪ Nausea ▪ Hiccups ▪ Cough ▪ Heartburn ▪ Headache ▪ Flatulence ▪ Insomnia	▪ Local skin reactions (erythema, pruritus, burning) ▪ Headache ▪ Sleep disturbances (insomnia, abnormal/vivid dreams); associated with nocturnal nicotine absorption	▪ Nasal and/or throat irritation (hot, peppery, or burning sensation) ▪ Rhinitis ▪ Tearing ▪ Sneezing ▪ Cough ▪ Headache	▪ Mouth and/or throat irritation ▪ Cough ▪ Headache ▪ Rhinitis ▪ Dyspepsia ▪ Hiccups	▪ Insomnia ▪ Dry mouth ▪ Nervousness/difficulty concentrating ▪ Nausea ▪ Dizziness ▪ Constipation ▪ Rash ▪ Seizures (risk is 0.1%) ▪ Neuropsychiatric symptoms (rare; see PRECAUTIONS)	▪ Nausea ▪ Sleep disturbances (insomnia, abnormal/vivid dreams) ▪ Constipation ▪ Flatulence ▪ Vomiting ▪ Neuropsychiatric symptoms (rare; see PRECAUTIONS)
Advantages	▪ Might serve as an oral substitute for tobacco ▪ Might delay weight gain ▪ Can be titrated to manage withdrawal symptoms ▪ Can be used in combination with other agents to manage situational urges	▪ Might serve as an oral substitute for tobacco ▪ Might delay weight gain ▪ Can be titrated to manage withdrawal symptoms ▪ Can be used in combination with other agents to manage situational urges	▪ Once-daily dosing associated with fewer adherence problems ▪ Of all NRT products, its use is least obvious to others ▪ Can be used in combination with other agents; delivers consistent nicotine levels over 24 hours	▪ Can be titrated to rapidly manage withdrawal symptoms ▪ Can be used in combination with other agents to manage situational urges	▪ Might serve as an oral substitute for tobacco ▪ Can be titrated to manage withdrawal symptoms ▪ Mimics hand-to-mouth ritual of smoking ▪ Can be used in combination with other agents to manage situational urges	▪ Twice-daily oral dosing is simple and associated with fewer adherence problems ▪ Might delay weight gain ▪ Might be beneficial in patients with depression ▪ Can be used in combination with NRT agents	▪ Twice-daily oral dosing is simple and associated with fewer adherence problems ▪ Offers a different mechanism of action for patients who have failed other agents
Disadvantages	▪ Need for frequent dosing can compromise adherence ▪ Might be problematic for patients with significant dental work ▪ Proper chewing technique is necessary for effectiveness and to minimize adverse effects ▪ Gum chewing might not be acceptable or desirable for some patients	▪ Need for frequent dosing can compromise adherence ▪ Gastrointestinal side effects (nausea, hiccups, heartburn) might be bothersome	▪ When used as monotherapy, cannot be titrated to acutely manage withdrawal symptoms ▪ Not recommended for use by patients with dermatologic conditions (e.g., psoriasis, eczema, atopic dermatitis)	▪ Need for frequent dosing can compromise adherence ▪ Nasal administration might not be acceptable or desirable for some patients; nasal irritation often problematic ▪ Not recommended for use by patients with chronic nasal disorders or severe reactive airway disease	▪ Need for frequent dosing can compromise adherence ▪ Cartridges might be less effective in cold environments (≤60°F)	▪ Seizure risk is increased ▪ Several contraindications and precautions preclude use in some patients (see PRECAUTIONS) ▪ Patients should be monitored for potential neuropsychiatric symptoms[5] (see PRECAUTIONS)	▪ Should be taken with food or a full glass of water to reduce the incidence of nausea ▪ Patients should be monitored for potential neuropsychiatric symptoms[5] (see PRECAUTIONS)
Cost[6]	2 mg or 4 mg: $1.90–$3.70 (9 pieces)	2 mg or 4 mg: $2.66–$4.10 (9 pieces)	$1.52–$3.48 (1 patch)	$5.57 (8 doses)	$8.47 (6 cartridges)	$2.58–$6.84 (2 tablets)	$10.14 (2 tablets)

[1] Marketed by GlaxoSmithKline.
[2] Marketed by Niconovum USA (a subsidiary of Reynolds American, Inc.)
[3] Marketed by Pfizer.
[4] The U.S. Clinical Practice Guideline states that pregnant smokers should be encouraged to quit without medication based on insufficient evidence of effectiveness and theoretical concerns with safety. Pregnant smokers should be offered behavioral counseling interventions that exceed minimal advice to quit.
[5] In July 2009, the FDA mandated that the prescribing information for all bupropion- and varenicline-containing products include a black-boxed warning highlighting the risk of serious neuropsychiatric symptoms, including changes in behavior, hostility, agitation, depressed mood, suicidal thoughts and behavior, and attempted suicide. Clinicians should advise patients to stop taking varenicline or bupropion SR and contact a health care provider immediately if they experience agitation, depressed mood, or any changes in behavior that are not typical of nicotine withdrawal, or if they experience suicidal thoughts or behavior. If treatment is stopped due to neuropsychiatric symptoms, patients should be monitored until the symptoms resolve.
[6] Wholesale acquisition cost from Red Book Online. Thomson Reuters, September 2015.

Abbreviations: MAO, monoamine oxidase; NRT, nicotine replacement therapy; OTC, over-the-counter (nonprescription product); Rx, prescription product.

For complete prescribing information and a comprehensive listing of warnings and precautions, please refer to the manufacturers' package inserts.

Source: University of California, San Francisco Schools of Pharmacy and Medicine. Rx for change curricula (http://rxforchange.ucsf.edu/

Appendix L: NRT Storage and Distribution Procedures

Montrose Center

Peer Services Process
Re-entry Documentation

20.5 TOBACCO CESSATION
20.5.1 MY QUIT KIT PROGRAM

My Quit Kit Program is offered in conjunction with Tobacco Cessation Services targeting the LGBTQ and adults living with HIV with substance use and other mental health conditions, and designed to deliver commercially-available over-the counter nicotine replacement therapy (NRT) products for self-administration at no cost to participants. The program complements other available cessation supports and resources, including cessation support services offered by the Center via individual counseling, peer recovery support services and Way Out Recovery treatment program. The duration of the program is dependent upon available funds and supplies, and is initially supported through a formal partnership with the Taking Texas Tobacco Free Project (TTTF).

Although these products are made available through the Montrose Center's Education Department and not prescribed to participants nor administered on site, the program adheres to §448.802 and §448.414 of the Texas Administrative Code *as applicable* concerning informed consent for participation as well as handling and distribution of NRT products.

Eligibility: All adult (18+) consumers and employees who wish to quit tobacco products are eligible for My Quit Kit Program. In the event that NRT supplies become limited, preference shall be given to clients who are enrolled in the Center's Integrated Treatment Program for Co-occurring Disorders (ITP). These are individuals who identify as LGBTQ and/or are living with HIV and have mental health, substance use or co-occurring disorders. Note: Employees may enroll in the program through Employee Assistance Program and their data will be tracked for the funding source by the staff member administering the program but not be entered into CONTINUUM.

Referral: New and existing clients may be referred to Tobacco Cessation Services through any service provider (clinician, specialist, assistant, or intern) to the designated Health Educator. The Health Educator shall screen for and determine whether NRT access is indicated. Employees and other community members may self-refer to the designated Health Educator via contact information shared in promotional materials, or via front desk. Refer to Tobacco Cessation Services.

Enrollment and Orientation: All My Quit Kit participants shall first be enrolled in Tobacco Cessation Services. In addition, participants shall be oriented by the HE, which may be done during enrollment, and complete the following:

- Client Handbook
- My Quit Kit Participant Application
- My Quit Kit Participant Agreement with Informed Consent
- My Quit Kit Handbook

During the orientation, the Health Educator shall review the scope of the program, client rights and responsibilities, expectations for successful participation, and review all aspects of the agreement and informed consent form. This information shall be explained to the participant in simple, non-technical terms. If an emergency or the client's physical or mental condition prevents the explanation from being given or understood by the client within 24 hours, staff shall document the circumstances in the client record and present the explanation as soon as possible. Documentation of the explanation shall be dated and signed by the participant and the Health Educator.

The client record shall include a copy of the Client Bill of Rights dated and signed by the client and consenter. If possible, all information shall be provided in the participant's primary language. If an individual is not admitted, the program shall refer and assist the applicant to obtain appropriate services. When an applicant is screened and determined to be eligible for services but denied admission, the Center shall maintain documentation signed by the Recovery & Wellness Program Coordinator (QCC) which includes the reason for the denial and all referrals made.

the Montrose Center 3/16, 3/19

The Health Educator shall collaborate with the participant to develop the My Quit Plan which includes at a minimum, a target quit date, identified support resources (individual and/or group peer support, online and community resources) and NRT product regimen corresponding to the recommended dose and based on their product preference (see Regimen below). The Health Educator shall enter the plan in CONTINUUM.

Distribution: After orientation with the Health Educator, the participant shall be given a kit containing an initial 4-week supply (Step One) of nicotine patches, nicotine gum and/or lozenges. The kit shall also include a voucher for an additional 4-6 week supply (Steps Two & Three) redeemable by calling the Health Educator and scheduling a time to pick-up the next kit. Contact instructions shall be printed on the voucher. The recommended regimen and dosage information shall be indicated by the Health Educator and included in the client's My Quit Kit Handbook. Each distribution shall be documented by the Health Educator under the client's CONTINUUM record, under the Medical tab, Medication Information section with type, start/stop date, dose and quantity.

Participant Data and Outcomes: The application form includes participant name, address, phone, email, date of birth, sexual orientation, gender identity, primary care provider information, emergency contact information, and known drug allergies. A unique 11-digit character code shall be assigned to each participant for purposes of reporting and outcomes analysis. No personal information shall be shared with partners or the public, as stated in the Client Rights and Responsibilities Existing clients with a current CONTINUUM record may enter their name and skip to the "ABOUT YOUR TOBACCO USE" section of the form.

All paper forms with participant information are subject to existing confidentiality policies and are to be compiled in individual participant files and stored in a locked file cabinet in the education suite by the Health Educator.

Utilization and outcomes data shall be entered into CONTINUUM by the Health Educator, including kit contents (quantity and regimen), enrollment date, delivery date, and dates and kit contents associated with follow-up voucher redemption.

The Health Educator shall have contact with each participant in 9-12 weeks after enrollment, regardless of follow-up or voucher redemption, to determine whether the participant is continuing with NRT and was successful in quitting, and to provide additional cessation resources as needed.

Product Storage and Inventory: Product inventory shall be the responsibility of the Recovery & Wellness Program Coordinator. All NRT products shall be inventoried upon arrival by the Recovery & Wellness Program Coordinator, and entered into an inventory spreadsheet in a restricted folder on the primary server. The Program Coordinator shall conduct a quarterly inventory and document any disposed product in the spreadsheet. Actual disposal of damaged or expired product shall be done by the Program Coordinator, who shall have a witness present. A completed §19.7.10.1 Consumable Goods Disposal Form signed by both the Program Coordinator and witness shall be submitted to the Bookkeeper, and documented by the Program Coordinator in the inventory spreadsheet. Product back-stock shall be stored in the locked 3rd floor server room, accessible only by the Executive Director, Operations & Prevention Director, Chief Development Officer and IT & Property Management Specialist. The Health Educator may request and keep up to one month of "on hand" NRT supplies to fulfill anticipated consumer demand in a locked cabinet in the 3rd floor prevention suite. The Health Educator shall document on-hand product in a distribution spreadsheet in a restricted folder on the primary server and as a medication in CONTINUUM.

The Bookkeeper shall compare the physical inventory with both the inventory and distribution spreadsheets on a quarterly basis. Any discrepancies shall be reported to the Executive Director.

20.5.3 MY QUIT KIT PROGRAM PARTICIPANT AGREEMENT WITH INFORMED CONSENT

I, (Participant Name):_____ am requesting enrollment in the My Quit Kit Program of the Montrose Center. As a participant in this program, I understand and agree to the following statements and requirements: (*please initial each statement*)

___ I certify that all of the information provided above is correct.

___I understand that the nicotine replacement therapy (NRT) product(s) I am receiving is/are used to treat addiction to nicotine; and that these products contain nicotine.

___I understand that the products are being offered free-of-charge to me and paid for with limited grant funds through a partnership between the Montrose Center and Taking Texas Tobacco Free Project; and that additional supplies will be offered only as supplies are available, and contingent upon my following the program expectations as described in this agreement.

___I understand that the NRT products I am receiving through My Quit Kit are a commercially-available over-the-counter products, and that they are not being directly administered or prescribed to me by the Montrose Center staff or any other individual, company or institution.

___I understand that these products are for personal use, and not to be shared, sold or otherwise distributed to anyone else.

___I agree to be screened by a Health Educator at the Montrose Center for program eligibility, and to receive education about tobacco cessation and health risks associated with continued tobacco use.

___In exchange for receiving these products, I agree to communicate with the Health Educator periodically during the next six (6) months either via phone, email, or in person, to share information about how I have been using the products, whether they have been helpful to me in my efforts to reduce or discontinue tobacco use, and about other support services and resources I have been using to discontinue/reduce tobacco use. I understand that failure to share this information or respond to follow-up attempts by the Health Educator may result in inability to continue in the program.

___I understand that, based on my self-reported smoking/tobacco use patterns and stated product preference, the recommended course of self-administered NRT treatment is as follows:

☐ Nicotine Patches	Weeks 1-4:	___mg every ___hours
	Weeks 5-8:	___mg every ___hours
	Weeks 9-12:	___mg every ___hours
☐ Nicotine Gum	Weeks 1-4:	___mg every ___hours
	Weeks 5-8:	___mg every ___hours
	Weeks 9-12:	___mg every ___hours
☐ Nicotine Lozenges	Weeks 1-4:	___mg every ___hours
	Weeks 5-8:	___mg every ___hours
	Weeks 9-12:	___mg every ___hours

___I understand that the above recommendations for self-administered NRT treatment is based on published product use directions, information that is broadly available on the internet by reputable sources such as the American Cancer Society and US Veterans Administration, and customized for me by the Health Educator employed by the Montrose Center based upon my self-reported average daily tobacco use.

___I understand that the expected benefits of NRT are decreased dependence on tobacco products (cigarettes, cigars, pipes, smokeless) and other nicotine delivery systems by reducing nicotine withdrawal symptoms while gradually stepping down the daily dosage of nicotine in the NRT products I am using.

___I understand that the probable consequences of not consenting to utilize NRT may include experiencing more intense withdrawal physical symptoms, increased physical and psychological distress during the withdrawal period, and greater difficulty with quitting tobacco use and avoiding relapse if I do choose to

discontinue or significantly reduce tobacco products; and all of the health risks associated with continued tobacco use should I choose not reduce or discontinue use of tobacco products.

___I understand that the side effects of using NRT products as recommended may be similar to any tobacco or "vaping" product containing nicotine. In addition, I understand that according to the American Cancer Society:

- possible side effects associated with the use of subdermal nicotine patches may include skin irritation (redness and itching), dizziness, racing heartbeat, sleep problems or unusual dreams, headache, nausea, muscle aches and stiffness; and
- possible side effects associated with use of nicotine-containing gum or lozenges may include bad taste, throat irritation, mouth sores, hiccups, nausea, jaw discomfort, racing heartbeat, and nausea.

___I understand that there exists a risk of nicotine overdose if NRT products are not used as recommended and/or in combination with continued tobacco use, with side effects that, according to the American Cancer Society, may include headache, nausea and vomiting, belly pain, diarrhea, agitation, restlessness, fast or irregular heartbeat, cold sweat, pale skin and mouth, weakness, tremors (shaking), confusion, disturbed vision and hearing, weakness, high blood pressure which then drops, dizziness or faintness due to low blood pressure, seizures, fast breathing in early poisoning that may stop later.

___I understand that there are alternatives to NRT for tobacco cessation including quitting abruptly or "cold turkey;" gradual reduction and discontinuation of tobacco use over time; counseling interventions such as talk therapy, group therapy, hypnosis, relaxation and stress reduction techniques; individual coaching and individual or group peer support; and medical intervention including prescription medications that may help reduce cravings and withdrawal symptoms, e.g., varenicline (Chantix) and bupropion (Wellbutrin). Furthermore, I understand that research suggests that prescription medication interventions are associated with the highest rates of success. I understand that all above alternatives **with the exception of the aforementioned prescription medication** and **gradual reduction of tobacco use** are appropriate for simultaneous use with NRT.

___I understand that the Health Educator providing this service is an employee of the Montrose Center who has completed the Certified Tobacco Treatment Training Program at the University of Texas MD Anderson Cancer Center, and is qualified to provide guidance and education about the health issues and risks associated with tobacco use as well as a variety of risk reduction and cessation techniques. I understand that the Health Educator is **not** medical professional and is not authorized to *prescribe* or *administer* any medications, including NRT.

___I agree that I will consult with a physician before initiating self-administered NRT treatment as encouraged by the Health Educator.

___I understand that services available to family members include education, participation in group level peer support, accompanying me to initial and follow-up appointments with the Health Educator, up to full participation in the program as eligible.

___I agree that I have received, read and understand the My Quit Kit Handbook which explains the scope of the program and services I am eligible for, how to access services, rules for continued participation including consequences for non-compliance and conditions for participation being expelled, cost for services (free-of-charge).

___I agree that I have received, read and understand the Montrose Center Client Handbook which explains my rights and responsibilities as a client, including Client Bill of Rights, policies governing confidentiality of my private information, complaint and grievance procedure, description of services available to me and family members, fees for services, the program rules and HIPAA Privacy Act Notice.

___I agree that this information has be explained to me in simple, non-technical terms, and that I have had the opportunity to ask questions and have them answered in a manner that I was able to understand.

WAIVER OF LIABILITY

___I agree to release, hold harmless and indemnify the Montrose Center [the Center], their board of directors, officers, agents, employees, and insurers for any claims brought by myself for any injury or damage resulting from any cause, including negligence, which arise out of taking nicotine replacement therapy (NRT) products and participation in the My Quit Kit program. This release is binding as to any other persons, including family members, heirs, and executors.

___I hereby waive the right to take any legal action against the Center and agree and affirm to hold harmless the Center from any legal or equitable cause of action, for any reason arising from my participation in the My Quit Kit Program and/or use of NRT products.

INFORMED CONSENT

By signing this form, I agree and affirm that I am giving up the right to bring legal action. I further agree that, notwithstanding this agreement, the Center reserves the right to mandatory mediation and/or arbitration, in any appropriate jurisdiction, as to any and all potential legal actions against it, both now or at any point and in the future.

By signing this form, I am consenting to participation in the My Quit Kit Program. I understand the specific condition to participate and services to be received; the program's services and process; the expected benefits of participation; the probable health and mental health consequences of not consenting; side effects and risks associated with the NRT products I am receiving and generally accepted alternatives.

I have been informed that there is no charge for participation or for the NRT products I am receiving; the name and qualifications of the staff who will provide the service; expectations for my participation, the Statement of Client Rights and Responsibilities and Complaint/Grievance Procedures. I have been given a client handbook and a My Quit Kit Handbook.

I understand the program rules and have received a copy of them. I understand the consequences of violating the rules as explained in this agreement. Violation can include being expelled from the program. The program's objective have been discussed with me and I have been able to get answers to any questions I have about them. I have been given a list of resources for me and my family.

X_____ _____/_____/_____
Participant's Signature Date

_____ _____/_____/_____
Health Educator's Signature Date

Denton County MHMR

Section No: 3.14.02	Page 65 of 2
Policy: CLIENT SERVICES SYSTEM Subject: NICOTINE REPLACEMENT THERAPY STORAGE AND ALLOCATION	APPROVED BY: _____ Medical Director _____ Administrator of Human Resources CONCURRED: _____ Chief Executive Officer
Effective Date: 06/01/2015	Revised Date:

I. **PURPOSE:** Purpose of this procedure is to help guide tobacco use assessment, distribution, and storage of NRT and staff training.

II. **SCOPE:** As a CPRIT grant recipient, provide staff and clients with training and education related to tobacco use, provide NRT and provide support in terms of eliminating use of tobacco.

III. **PROCEDURE:** The Center's continued efforts to provide a benefit of a healthy work environment for employees, clients, visitors, volunteers and vendors, and in compliance with the Tobacco Free Workplace Policy, has established a Tobacco Free workplace procedure.

IV. **GLOSSARY:**

1. **DCMHMRC:** Denton County MHMR Center
2. **HR:** Human Resources
3. **NRT:** Nicotine Replacement Therapy
4. **Clients:** Active clients registered in care or active in center's 1115 programs
5. **Staff:** Employee of the DCMHMRC
6. **TCQ:** Tobacco Cessation Questionnaire

V. **DCMHMRC STAFF TRAINING:**

Center staff will be offered training and will continue to receive ongoing education and training related to tobacco cessation questionnaires, cessation and supporting clients in cessation of tobacco use. Printed material will be available for client's distribution and education. Record of this training will be documented in and monitored by HR.

VI. **NRT STORAGE:**

a. The stock supply of NRT will be stored and monitored by methods to ensure safety and security.
b. All NRT will be kept under lock in the designated storage area of the center facilities.
c. Only designated staff will have access to the locked storage area.

NRT will be inspected and counted monthly by designated nursing staff to ensure those outdated or deteriorated products are removed from the stock. NRT in need of disposal will be disposed of as per center medication disposal policy. Monthly audit report will be submitted to HR.

d. If NRT products are recalled by FDA or other agency, such NRT stock will be collected and returned to the manufacturer or disposed of in accordance with instructions provided. Center staff would provide notice to clients or staff affected by the recall or discontinuation.
e. NRT will be kept separate from disinfectants and cleaning products.

VII. TOBACCO USE ASSESSMENT:

a. Initial screening for desire to quit may be done at intake, with a nursing assessment or by case manager
b. Clients may receive TCQ by a case manager at any time in or outside of the clinic.
c. TCQ is completed annually to keep track of tobacco use and quit attempt.
d. If a client is not interested in quitting, note and document client's decision, assess client's desire to quit on an ongoing bases.
e. Children assessed for smoking in home. If caregiver is using tobacco products, offer education of dangers of second hand smoke and offer smoking cessation resources available in the community to care givers.
f. No TCQ will be administered to any minors.

VIII. NRT ALLOCATION:

a. In order to receive the over the counter NRT, the client must meet with the designated program or clinic staff and complete the TQA and determine the amount of NRT. Staff must meet with the designated HR staff and complete the TQA to receive a two week supply of NRT.
b. Once the client's amount is determined, only a two (2) week supply will be provided at one time. If the client decides to continue NRT, they will need to meet with the designated staff prior to receiving next two (2) week allocation. The client's treating clinician will be informed when the client receives NRT supply.
c. Allocation of NRT will be documented accordingly and for clients will become part of their permanent record, for staff documentation will be maintained by HR.
d. Clients can receive up to 12 weeks of NRT per calendar year. Staff can receive two (2) week supply of NRT after which staff will be provided referral to available resources.
e. Crisis Residential Unit, Psychiatric Triage, and Intake will receive a supply of NRT gum to provide to clients as a temporary alternative to using tobacco products while on Center property.
f. Individuals will be provided written notification of the side effects associated with NRT.
g. Individuals will be notified and will sign acknowledging that they are aware of the following:
    i. NRT is an over the counter product
    ii. NRT is not being prescribed by staff at DCMHMRC.
    iii. Medical oversight is not being provided.
h. If a client has Medicaid or other insurance, the client may receive tobacco cessation aids (such as Zyban, Chantix, Nicoderm, Nicorette) if covered by their insurance and deemed clinically appropriate by treating clinician.
i. No NRT will be allocated to minors.

Should the center run out of NRT, clients will be given referral sources to assist them in continuing with their tobacco cessation.

Appendix M: Tobacco-free Policy Anniversary